

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████

Petitioner,

v

File No. 149826-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 9th day of October 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) questioned the out-of-pocket costs she incurred for medical services she received in December 2014. She also questioned a change in her health care coverage from Blue Cross Blue Shield of Michigan (BCBSM) that was effective December 1, 2014.

On September 14, 2015, she filed a request with the Director of Insurance and Financial Services seeking a review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On September 21, 2015, after a preliminary review of the information submitted, the Director accepted the request.

At the time the Petitioner received the health care services that are at issue in this review she was covered through a small group plan that is underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on September 29, 2015.

This issue of the Petitioner's out-of-pocket costs can be resolved here by applying the terms of the Petitioner's coverage; a medical opinion from an independent review organization is not required. MCL 550.1911(7). The issue of the change in coverage cannot be addressed in this review as explained below.

II. FACTUAL BACKGROUND

From January 1 through November 30, 2014, the Petitioner was covered under a health plan whose benefits were defined in BCBSM's *Simply Blue Health Savings Account without Prescription*

Drug Coverage Group Benefits Certificate. Under that plan, services from panel (network) providers were subject to a \$6,000 annual deductible but there was no coinsurance for panel provider services.

On December 1, 2014, the Petitioner's health plan changed. The new plan's benefits were defined in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG*.¹ *Rider SB-HSA-\$3000 SG Simply Blue HSA Cost-Sharing Requirements* amended that certificate to impose a 30% coinsurance for services from panel providers. The rider also established an annual out-of-pocket maximum of \$12,700.00 for a family contract (two or more members).

From December 3 to December 24, 2014, the Petitioner received both inpatient and outpatient medical services from panel providers. BCBSM covered those services but applied 30% coinsurance, leaving the Petitioner responsible out-of-pocket for \$5,725.40.

The Petitioner, questioning the application of coinsurance to the December 2014 services, appealed through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated July 22, 2015, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ANALYSIS

In its final adverse determination, BCBSM explained to the Petitioner how it processed the claims for the services she received in December 2014:

On the dates of service in question, you were covered under the *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG*. Your out-of-pocket payment responsibilities were defined in **Section 7: The Language of Health Care**. . . . On page 152, coinsurance was defined as "a percentage of the approved amount that you must pay for a covered service after your deductible . . . has been met." Your certificate was amended by *Rider SB-HSA-\$3000 SG*, which provided that, after your deductible had been met, charges would be applied to your coinsurance at the rate of 30 percent of the approved amount for most covered in-network services. Your in-network deductible and coinsurance payments were combined to accumulate towards your annual in-network out-of-pocket maximum, and once that was satisfied, all covered benefits performed by in-network providers were to be covered at 100 percent. Your rider set your in-network out-of-pocket maximum amount at \$12,700.00 for your two-person Contract.

Your *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG* went into effect on December 1, 2014. As a result, your out-of-pocket maximum increased. . . . Under your earlier benefit package, which was effective between January 1 and November 30, 2014, your in-network family deductible was \$6,000. You had no additional coinsurance responsibility for in-network services.

¹ BCBSM form no. 913F; federal approval 9/2013, state approval 08/14.

Our records reflect that, under your earlier benefit package, you met your \$6,000 family deductible with services you received on November 17, 2014.

When your coverage changed on December 1, 2014, you were credited with the \$6,000 that you had already made in deductible payments under your previous benefit package. However, you also became responsible for the 30 percent coinsurance that began to apply to most covered services. The coinsurance charges that applied to the services you received in December, 2014 totaled \$5,725.40, and your out-of-pocket maximum was not met for 2014.

The Director reviewed the explanation of benefit statements for the December 2014 services and concludes that BCBSM, as it explained above, correctly processed the claims under the terms of the coverage that went into effect on December 1, 2014. Those services were subject to 30% coinsurance until the \$12,700.00 out-of-pocket maximum was reached. The Petitioner was credited with \$6,000.00 from the prior plan toward the deductible in the new plan but she was still responsible for coinsurance under the new plan. Because she had not reached the out-of-pocket maximum, she was responsible for coinsurance in the amount of \$5,725.40.

The Petitioner does not really dispute BCBSM's processing of the claims for the December 2014 services. Her fundamental argument is that her coverage unduly changed on December 1, 2014. She explained her position in a March 10, 2015, letter to BCBSM:

. . . In November, I was hospitalized in ICU for a pulmonary issue. During that time my husband learned that our BCBSM group plan was no longer compliant under the Affordable Care Act and our plan would no longer be available in 2015.

I am requesting a full review of my expenses and coverage in 2014. We were forced to change plans three times since November [2014]. I am seeking relief due to hardship. As I understand it, if we would have been allowed to continue our original group plan for the duration of the 2014 contract year I would not be facing this personal liability in excess of \$12,000. It is unclear to me why the new marketplace coverage option with BCBSM would not have commenced on January 1, 2015 at the expiration of the 2014 group plan.

Our [insurance] agent . . . advised us we had to sign up for the individual marketplace policies no later than November 17th if we were no longer going to offer group coverage to our employees. That is fine and well except with payment it should have been effective January 1, 2015 not December 1, 2014. I was scheduled for surgery in December to repair the cause of my November health crisis. It had to be postponed for two weeks for further evaluation but it was not presented to me as elective and the matter required surgery as soon as possible.

It still doesn't see reasonable that we would have been forced to agree to a different BCBSM group . . . for the month of December until the marketplace coverage was to begin January 1, 2015. They exposed us to increased deductibles and a significant

increase in copays. We had satisfied all the deductibles and copay under our original group plan which was in effective until December 31, 2014.

It is the Petitioner's contention that the prior coverage was to be in effect from January 1 through December 31, 2014, and thus the services in December 2014 should have been covered with no cost sharing because she had already met the \$6,000.00 deductible in November 2014 and there was no coinsurance requirement. The Petitioner apparently does not know why the group coverage changed on December 1, 2014.

It is not explained in this record who was responsible for making the change in coverage on December 1, 2014. Nevertheless, that issue cannot be resolved in this external review. Under the Patient's Right to Independent Review Act, the Director can only determine if BCBSM correctly administered benefits according to the terms and conditions of the plan in effect on the date of service. The Director cannot review an employer's decision to change its group health plan.

The Director finds that BCBSM correctly applied the terms and conditions of the certificate and its rider in effect in December 2014 when it processed the Petitioner's claims.

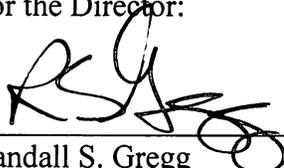
IV. ORDER

The Director upholds BCBSM's final adverse determination of July 22, 2015.

This is a final decision of an administrative agency. Any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the Michigan county where the covered person resides or in the circuit court of Ingham County. MCL 550.1915(1). A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director