

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. 148706-001

Health Alliance Plan of Michigan,

Respondent.

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Issued and entered  
this 30<sup>th</sup> day of July 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On July 7, 2015, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives group health care benefits from the Health Alliance Plan of Michigan (HAP), a health maintenance organization. The Director notified HAP of the external review request and asked for the information it used to make its final adverse determination. HAP submitted the information on July 9, 2015. The Director reviewed all the material submitted and accepted the Petitioner's request on July 16, 2015.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

**II. FACTUAL BACKGROUND**

The Petitioner's health care benefits are defined in HAP's *HMO Subscriber Contract* (the contract). *Rider 301 Health Engagement Program* (the rider) amended the contract to establish a program that "rewards health lifestyle choices" (known as the Aspire Health Engagement Program or Aspire).<sup>1</sup>

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<sup>1</sup> Health maintenance organizations are permitted to offer programs like Aspire which reward health lifestyle choices through reduced cost sharing. See section 3426 of the Insurance Code, MCL 500.3426.

Aspire promotes good health by offering “enhanced benefits” (lower copayments, coinsurance, and deductibles) if certain requirements are met. HAP members who do not adopt or maintain healthier behaviors receive “standard benefits.”

On January 1, 2014, the Petitioner was initially enrolled in Aspire with enhanced benefits. In order to continue to receive enhanced benefits in 2015, the Petitioner was required to complete three steps by March 31, 2015:

- have her physician complete the member qualification form (MQF);
- obtain a score of at least 80 points on the MQF; and
- complete the online health risk assessment (HRA).

The Petitioner’s physician completed the MQF but according to HAP the Petitioner did not submit her completed HRA by the March 31, 2015, deadline. As a result, HAP placed her in the standard benefits plan, with higher out-of-pocket expenses, effective April 1, 2015.

The Petitioner appealed HAP’s decision through its internal grievance process. At the conclusion of the grievance process, HAP issued a final adverse determination dated June 10, 2015, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did HAP correctly place the Petitioner into the Standard Benefits effective April 1, 2015 and her family from enhanced benefits in the Health Engagement Program?

### IV. ANALYSIS

#### Petitioner’s Argument

The Petitioner explained her argument in a letter that was submitted with her external review request:

. . . I am a kidney transplant patient and take several medications, have bloodwork done several times per year and see several doctors in order to maintain my current level of health and reduce the risk of losing my transplant. I am having a difficult time paying the extra fees I am incurring, as a result I am not able to have all of the tests and bloodwork my doctors want me to have as I am not able to pay for them. I am incurring these extra fees since HAP moved me from the enhanced benefit level to the standard benefit level and I feel this change was unfairly made by HAP.

I am [asking] for assistance with my HAP plan with being moved back into the enhanced benefit plan with the lower copays and to be reimbursed for the extra costs I have incurred.

I have a HAP Aspire plan and when my employer changed to this plan back in 2014 I followed the steps to obtain the enhanced benefit, I completed the on-line health assessment and had my primary care physician complete [the] member qualification form and I received a qualifying score and was in the enhanced plan for all of 2014.

However HAP moved me from the enhanced benefit plan to the standard benefit plan effective 04/01/2015. HAP stated I was moved into the standard benefit level since I did not retake the online health assessment. I believe I completed this on my tablet but since they do not send out any kind of email confirming you completed the assessment I have no proof.

HAP states they mailed out a reminder letter on January 2015 . . . that I had not completed the steps required to maintain the enhanced benefits. However this is a very generically worded letter and is not specific as to what steps were not completed to maintain the enhanced benefits. Since I had not been to see my doctor yet I thought that is what the letter was referring to.

I feel their reminder letter is very generic, vague, and does not specify what part of the process was not completed. I feel . . . their communication regarding this situation was very poor and ineffective.

Additionally during the qualification period, which we were informed was January-March 2015 I had extenuating circumstances I feel should be taken into consideration when reviewing my appeal. I was on medical leave from work due to extremely debilitating abdominal pain. During this time I was on Vicodin, Cyclobenzaprine and Oxycodone every day just to control the pain and had reduced mental and physical capabilities as a result. . . .

### Respondent's Argument

In its final adverse determination, HAP explained its decision to the Petitioner:

We upheld the denial because the Health Risk Assessment. (HRA) was not completed during the qualification period. The qualification period for [your group plan] was from October 1, 2014 to March 31, 2015. Our records indicate you completed the HRA on May 3, 2015 which was after the March 31, 2015 qualification period.

In a letter to the Petitioner dated May 18, 2015, HAP explained what it had done to remind her to complete the steps to remain in the enhanced benefits level:

Our records show a Welcome Kit and reminder letters were mailed to you on December 8, 2014, which includes the program information, MQF, and instructions on how to complete the HRA. The reminder letter #1 was mailed on January 30, 2015 and reminder letter #2 was mailed on February 26, 2015 encouraging you to complete all requirements before the deadline.

### Director's Review

The rider, in Section B, explains what needs to be done to retain enhanced benefits in subsequent enrollment years:

Eligible Members who have qualified to earn Enhanced Benefits in their preceding year may continue to earn Enhanced Benefits by following the steps outlined in "How to Earn the Health Engagement Program Enhanced Benefits in the First Year of Enrollment", in Section A. These steps will begin on the date of renewal of each year of the enrollment.

One of the steps in Section A is to complete the Health Risk Assessment (HRA) within 90 days of enrollment (i.e., by March 31, 2015). There is no exception in the rider to that requirement.

The Petitioner says she thought she had completed the HRA but had no proof. In any event, HAP sent her a reminder dated February 24, 2015. Although the Petitioner said of an earlier reminder letter that it was "very generic, vague, and does not specify what part of the process was not completed," the February letter was very specific:

Our records show that you have not yet completed your HRA. To do this by 03/31/2015, log in at hap.org and click "Health Risk Assessment" from the "Quick Links" section. You can also access the HRA or check your status online by clicking "Health Engagement" from the "My Plan" tab.

There is nothing in the record to show that the Petitioner had submitted the HRA by March 31, 2015 (HAP says it was submitted on May 3, 2015). Therefore, the Director finds that HAP's decision to place the Petitioner in standard benefits after March 31, 2015, was consistent with the terms of the rider.

#### V. ORDER

The Director upholds Health Alliance Plan of Michigan's June 10, 2015, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, 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. A copy of the petition for judicial review should be sent to the Director of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director