

On June 24, 2013, the Petitioner was enrolled in the Aspire program. 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 29, 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 and her family into the standard benefits level of the Health Engagement Program?

IV. ANALYSIS

Petitioner's Argument

In her external review request, the Petitioner wrote:

HAP changed my family's plan from "Enhanced" to "Standard" considerably increasing my family's health care cost.

I am requesting that HAP reinstate my family into the "Enhanced" plan.

Per the Final Internal Adverse Determination the ID# is incorrect. My ID# is not [REDACTED] and the person with this ID# is not required to submit any requirements to maintain the "Enhanced" plan.

My physician completed my Member Qualification Form with more than a passing score.

My health status has not changed, is good and HAP does not have any increased financial risk.

There is precedence as HAP has reinstated a coworker's plan from the "Standard" plan to the "Enhanced" plan after an on-line assessment form was submitted late because the physician's Member Qualification form; the more important part of qualifying for the "Enhanced" plan was submitted within the qualifying time.

As I am not the primary insured, I did not receive the mailings identified in the Final

Internal Adverse Determination.

In an August 8, 2015 letter submitted with her request for review the Petitioner wrote:

Please consider any grace period pursuant to the Patient's Right to Independent Review Act for any requirement to maintain the HAP "Enhanced" plan.

My husband recently found out he needs to undergo a medical procedure that we will postpone until next year due to the costs if the decision by HAP is not overturned needlessly placing my husband's health in jeopardy.

Our health status has not changed for years.

Respondent's Argument

In its final adverse determination, HAP wrote to the Petitioner:

We upheld the denial because the Health Engagement (HE) requirements were not completed during the qualification period, which was October 1, 2014 – March 31, 2015 deadline.

- You did not complete the Health Risk Assessment (HRA) by the March 31, 2015 deadline. The HRA could have been completed anytime, during the qualification period.
- You were sent the following as reminders of the HE requirements and deadlines: a Welcome Kit on December 12, 2014, Ford Reminder Letter #1 on January 30, 2015, and Ford Reminder Letter #2 on February 26, 2015.

Director's Review

Rider 301 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 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 argues that she is not the primary insured so she did not receive the mailings identified in the final determination and notes that the member ID number listed on HAP's final adverse determination is incorrect and that the person listed with ID [REDACTED] is not required to meet any requirements. However, HAP has provided copies of the enrollment reminder letters dated January 27, 2015 and February 24, 2015 that are clearly addressed to the Petitioner. The February 24, 2015 letter

was very specific as to what was still required to meet requirements and the deadline by which the information must be received:

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.

The Petitioner also argues that her co-worker was granted an exception to the deadline and was allowed reinstatement into the enhanced benefit level even though the required documents were submitted after the March 31, 2015 deadline. Under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether HAP properly administered health care benefits according to the terms and provisions of the applicable coverage documents, in this case the *Subscriber Contract and Rider 301*. The Director has no authority to amend the terms of coverage because of an alleged exception made for another HAP member.

The Director found nothing in the record to show that the Petitioner submitted the HRA by the March 31, 2015 deadline. (HAP says it was submitted on April 2, 2015.) There is no exception to that requirement in the subscriber contract or rider.

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 Petitioner's benefit plan.

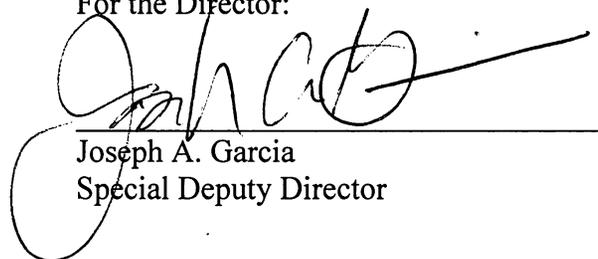
V. ORDER

The Director upholds Health Alliance Plan of Michigan's June 29, 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:



Joseph A. Garcia
Special Deputy Director