

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. 151936-001

US Health and Life Insurance Company
Respondent

Issued and entered
this 21st day of February 2016
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 4, 2016, ██████████, authorized representative of his son ██████████ (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 benefits through a group plan that is underwritten by US Health and Life Insurance Company (USHL). The benefits are defined in USHL's *Coalition of Public Safety Employees Health Trust Group Insurance Certificate*. The Director notified USHL of the external review request and asked for the information used to make its final adverse determination. USHL provided its response on February 9, 2016. After a preliminary review of the material received, the Director accepted the request on February 11, 2016.

This case presents an issue of contractual interpretation. 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

Between March 26 and March 30, 2015, the Petitioner received medical care at the Mayo Clinic in Rochester, Minnesota. USHL approved coverage for the treatment and processed the claims at the out-of-network benefit level.

The Petitioner appealed the benefit determinations through USHL's internal grievance process. At the conclusion of that process, on December 17, 2015, USHL issued a final adverse determination affirming its decision. The Petitioner now seeks the Director's review of that determination.

III. ISSUE

Did USHL correctly process the claims for Petitioner's March 2015 medical care?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination USHL wrote:

The group insurance provides for deductibles, higher copays, and coinsurance for out-of-network benefits. The group insurance coverage provides certain benefits when the employee and dependents receive services from network providers and certain other benefits when they receive services from providers that are not in the network. The benefit amount payable is based on the network status of the providers. Benefits are not based on the effort of the employees in attempting to obtain services from network providers or on the reasons they do not, such as an emergency. The insured is not required to use the services of any one particular provider.

In network and out-of-network benefits are different because of the discounts US Health and Life receives when an insured person receives treatment from a network provider. These discounts are not available from out of network providers. Policy benefits are based on whether a provider is in the network and provides a discount or is out-of-network. Benefits are not based on the availability of the providers.

According to the schedule of benefits, outpatient services from an out of network provider are subject to a \$100.00 individual deductible then payable at 80% of usual and customary. A schedule of benefits is attached for your reference. The claims were paid appropriately according to the schedule of benefits. Please note – since the claims were adjudicated the Plan has received update usual and customary guidelines. Several of the charges will be re-adjudicated shortly and you will receive an Explanation of Benefits outlining the reconsideration.

Petitioner's Argument

In a letter dated January 21, 2016, the Petitioner's father wrote:

I am writing this letter in regards to my request for an external review. In February/March 2015 I called US Health and Life to find out if The Mayo Clinic in Rochester, MN (at the suggestion of Cofinity) was in network. I gave US Health and Life the NPI # (1922074434) that all of the doctors there practice under. I was told that once my deductible was met, that the services provided by Mayo would be covered 100%. Now we are being told that the Mayo Clinic is out of network and that they will not cover it at 100%. These services should be covered at 100%. It is US Health and Life's responsibility to give out the correct information to its customers. I am not even sure at this point who my insurance company is. I thought it was US Health & Life. Then I was told Cofinity. US Health and Life has told me that they just pay what Cofinity tells them, but now they cannot tell me what services and doctors would be covered, that now I have to call Cofinity. This whole process is not user friendly. I have spent more time in the phone to get no answers. The bottom line is that we were told by US Health and Life that it would cost us 1200.00 out of pocket and the rest would be covered 100% by insurance.

I don't even know if the person that I am talking to at US Health & life or Cofinity is even qualified at what they are doing. Who am I supposed to believe? Both of these insurance companies have a duty to make sure that the personnel giving out the information to their customers is accurate. We should not be held accountable for their mistake. I have included a copy of my notes from our conversation with US Health & Life for you to review.

Director's Review

The Petitioner does not dispute the fact that the Mayo Clinic is not a network provider for his benefit plan. His argument is based on his assertion that he was told in a telephone call with a USHL employee that the Mayo Clinic services "would be covered 100%." This is not a false statement. After the deductible is paid, USHL did pay for the Mayo Clinic services at 100 percent of the approved amount for a non-network provider, after cost sharing requirements.

The Petitioner apparently interpreted the USHL employee's remark to mean that coverage would be 100 percent of the amount USHL pays to in-network providers. This interpretation is not consistent with the terms of the Petitioner's benefit plan which distinguishes coverage for in-network provider and out-of-network providers. See the Schedule of Benefits in USHL's *Coalition of Public Safety Employees Health Trust Group Insurance Certificate*.

In conducting external reviews under the PRIRA, the Director is limited to determining whether an insurer has correctly applied the terms of its benefit plan as written in its policy or certificate of coverage. The Director finds USHL processed the Petitioner's claims in a manner consistent with its certificate of coverage.

V. ORDER

The Director upholds US Health and Life Insurance Company's December 17, 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 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 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
Deputy Director