STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 112398-001**
v

Priority Health
Respondent
_____/

Issued and entered
this _ 9th_ day of March 2011
by Ken Ross
Commissioner

ORDER

I
BACKGROUND

On June 22, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On June 29, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Commissioner notified Priority Health of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Regulation received the information on July 2, 2010.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner is a member of Priority Health, a health maintenance organization. His health care benefits are defined in Priority Health's certificate of coverage and the HealthbyChoice Incentives rider.

HealthbyChoice Incentives is a wellness program that offers two levels of benefits: "choice" and "standard." Members who meet certain requirements qualify for the choice level which saves them money through lower copayments and deductibles.

The Petitioner enrolled with Priority Health effective January 1, 2010, and was placed in the choice benefit level. The requirements to remain at the choice level are explained in the rider:

> Services you receive during the first 90 days of Coverage under HealthbyChoice Incentives are automatically Covered according to the *choice* benefits level.
>
> To retain Coverage under the *choice* benefits level, you must meet the requirements described below during the first 90 days of your initial Coverage period. If you have a Covered spouse, your spouse must also meet these requirements during the first 90 days of your initial Coverage period:
>
> 1. Complete the online Health Quotient available at *priorityhealth.com*.
>
> 2. Have your Primary Care Provider (PCP) or other Participating Physician complete and submit your HealthbyChoice Incentives qualification form.
>
> 3. If you do not meet the criteria for the health indicators described on the qualification form, you must undergo appropriate screening tests and agree to follow your PCP's or other Participating Physician's treatment and monitoring plan.
>
> If you and your spouse do not meet these requirements within the first 90 days of your initial coverage period, subsequent services that you or your enrolled family Members receive will be Covered under the *standard* benefits level.

To remain at the choice level, the Petitioner had to complete the plan requirements within 90 days (i.e., by April 1, 2010). Priority Health terminated the Petitioner's enrollment in

the choice plan on April 2, 2010, and returned him to the standard level because he did not meet those requirements.

The Petitioner appealed the termination through Priority Health's internal grievance process and received a final adverse determination dated June 8, 2010.

III
ISSUE

Did Priority Health properly deny the Petitioner reinstatement to the choice plan under the terms of the rider?

IV
ANALYSIS

Petitioner's Argument

The Petitioner wants his participating at the choice level restored as of April 2, 2010. He said in his request for external review that he, as a new enrollee, did not understand the Health Quotient requirement and had trouble accessing Priority Health's website.

Notes from the grievance process indicate that the Petitioner assumed that Priority Health was waiting for some response from his physician and that he thought he had completed all the necessary steps when he registered on Priority Health's website.

Respondent's Argument

In its June 8, 2010, final adverse determination, Priority Health declined to restore the Petitioner to choice level of benefits because:

> Member and member's spouse did not complete the required steps during the qualifying period to allow continued coverage under the HealthbyChoice Incentives Choice benefit level. Specifically, member and member's spouse did not complete the online Health Quotient.

Priority Health says that on January 19 and February 15, 2010, it mailed letters to both the Petitioner and his wife explaining the requirements for continued enrollment at the choice level. However, the Petitioner did not complete his Health Quotient form by the April 1, 2010, deadline. As a result, Priority Health placed the Petitioner in the standard level of benefits.

Priority Health says that Petitioner did not meet the requirements to remain in the choice level and therefore its decision was appropriate.

Commissioner's Review

Health maintenance organizations are permitted to offer wellness programs that provide for reduced copayments, coinsurance, or deductibles if certain conditions are met. See MCL 500.3426. To remain in the choice level, the Petitioner had to meet the requirements in the rider, one of which was to complete the online Health Quotient questionnaire by a specific date.

The Petitioner was required to have the online Health Quotient form completed by April 1, 2010. There is no dispute that the form was not submitted by that date. The Petitioner says he misunderstood the program's obligations and wants to be put back in the choice level of coverage.

The Commissioner, while sympathetic, is unable to order the remedy sought by the Petitioner. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether Priority Health properly administered the terms and conditions of the Petitioner's coverage and state law. Nothing in the certificate, the HealthbyChoice rider, or state law requires Priority Health to waive the participation conditions of the wellness program. Priority Health's decision was consistent with the terms of the rider.

The Commissioner concludes that the Petitioner did not follow the requirements of the HealthbyChoice rider and finds that Priority Health's decision to place him in the standard level was permissible. The Commissioner notes that the Petitioner may reapply for the choice level at the next open enrollment.

V
ORDER

The Commissioner upholds Priority Health's June 8, 2010, 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 sixty 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Ken Ross
Commissioner