

**STATE OF MICHIGAN**  
**DEPARTMENT OF CONSUMER & INDUSTRY SERVICES**  
**OFFICE OF FINANCIAL AND INSURANCE SERVICES**  
**Before the Commissioner of Financial and Insurance Services**

In the matter of

XXXXXXXXXXXX

Petitioner,

File No. 53861-001

v.

Blue Cross and Blue Shield of Michigan

Respondent.

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**Issued and entered  
this 19<sup>th</sup> day of June 2003  
by Linda A. Watters  
Commissioner**

**ORDER**  
**I**  
**PROCEDURAL BACKGROUND**

On May 22, 2003, XXXXXXXXXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services (Commissioner) under the Patient's Right to Independent Review Act (PRIRA) MCL 550.1901 *et seq.* After a review of the material submitted, the Commissioner accepted the request on May 29, 2003.

The issue involved in the adverse determination is contractual. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). As a result, review by an independent review organization is not required. The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of Petitioner's filing and requested the information it used in making its adverse determination. The Office of Financial and Insurance Services received the BCBSM information on June 9, 2003.

**II  
FACTUAL BACKGROUND**

On XXXXXXXXXXX XXXXXXXXXXXXXXX and XXXXXXXXXXXXXXXXXXX, the Petitioner received certain outpatient laboratory services. The amount charged for these services was \$342.54. BCBSM denied payment because the Petitioner had not exhausted the waiting period for pre-existing conditions that applies to his coverage. Petitioner believes BCBSM is required to waive the waiting period for pre-existing conditions in his certificate and pay for the laboratory tests.

**III  
ISSUE**

Is Blue Cross and Blue Shield of Michigan (BCBSM) required to waive the Petitioner's pre-existing condition waiting period and pay for his laboratory tests?

**IV  
ANALYSIS**

Petitioner's Argument

The Petitioner had health care coverage through his employment with XXXXXXXXXXX. beginning in XXXXXXXXXXX. When he left that corporation in XXXXXXXXXXX, he elected to continue his health care coverage through the provisions of the federal law known as COBRA. He continued the COBRA coverage until the end of XXXXXXXXXXX. The Petitioner became XXXXXXXXXXXXXXX of XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX branch. As part of his compensation, he received fully paid BCBSM coverage under a one-subscriber group. He replaced the previous executive director as the one subscriber in this group. The coverage with BCBSM became effective on XXXXXXXXXXXXXXX.

To waive the pre-existing condition exclusion, at the direction of the agent for BCBSM, the Petitioner submitted evidence of creditable coverage from his previous health care coverage. BCBSM indicated the Petitioner met the requirement to waive the pre-existing condition exclusion, except he had not exhausted his COBRA benefits. The Petitioner does not believe he should be required to pay for his health coverage for the full COBRA period through his former employer when

beginning on XXXXXXXXXXXXXXX he had fully paid health care coverage through his new employer. He argues BCBSM is required to waive his pre-existing condition exclusion and pay for his lab services.

### BCBSM's Argument

Petitioner has health coverage under BCBSM's Comprehensive Health Care Co-payment Certificate CMM 250 (Certificate) as amended by the Rider WP 180 Waiting Period. The waiting period rider excludes treatment of pre-existing conditions for the first 180 days of the certificate. A pre-existing condition is defined in the rider as a condition for which medical advice, diagnosis, care or treatment was recommended or received within 180 days before the enrollment date.

Creditable coverage is defined by Rider WP-180 Section 1 as "Any health care coverage that you had for at least 18 months immediately preceding your application for nongroup coverage".

Creditable coverage will eliminate the waiting period for the pre-existing conditions described below as long as:

- There is no more than a 62-day break in your coverage
- You did not lose your prior coverage because of nonpayment of your premium or for fraud and
- Your most recent coverage was with a group (even if the coverage was for one day).

Note: If you were eligible for COBRA when your prior group coverage ended, you must have elected and exhausted COBRA coverage in order for your credible coverage to eliminate the pre-existing waiting period.

BCBSM argues that the Petitioner elected COBRA coverage from XXXXXXXXXXX until XXXX XXXX. He did not exhaust eighteen months of this coverage. Therefore, he did not meet all the requirements to waive the pre-existing condition exclusion. The laboratory tests provided to the Petitioner from XXXX to XXXXXXXXXXXXXXX were within the first 180-days after the BCBSM enrollment date, and they were for treatment of a pre-existing condition. They are not a covered

benefit under the Certificate.

### Commissioner's Review

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) MCLA 550.1402(b): MSA 26.600 (402B) includes provisions to allow a person to move one from job to another without having to incur a waiting period for pre-existing conditions under the health care coverage provided by the new employer. Under these provisions, a person can leave one job and continue his health care coverage through COBRA. Once he finds a new job, the new health care coverage cannot exclude a pre-existing condition, if the person has been without his group insurance for 63 days or less. These provisions do not require a person to exhaust his COBRA benefits before the pre-existing condition exclusion is waived.

HIPAA also has a provision that allows a person to purchase individual health insurance, without a pre-existing condition exclusion, after his employment-related health care coverage expires. In Michigan, BCBSM has been designated as the carrier that must offer individual coverage under these HIPAA provisions. The provisions for individual coverage require that a person elect and exhaust the COBRA option before he is eligible for the individual coverage. This provision makes sense because individual coverage is only offered if a person is not eligible for any other coverage. A person with COBRA coverage is covered until those benefits are exhausted.

In the Petitioner's case, he elected COBRA coverage after he left his job. A year later, he began a new job that provided fully-paid health care coverage through BCBSM. This coverage was through a one-person group because the Petitioner was the only person eligible for health insurance. The coverage became effective on XXXXXXXXXXXXXXXX. The Petitioner canceled the COBRA coverage at the end of XXXXX because his new employer was paying for his new health care coverage. There was less than a 63 day break in coverage. BCBSM bases its position on the fact HIPAA defines a group to be two or more persons. However, the Petitioner's BCBSM benefits were not considered individual coverage. His employer had covered other persons who previously

held

his job. Therefore, it was written for the employer and not in the name of the Petitioner. The fact the Petitioner was the only person covered by the employer does not alter these facts.

Based on the above analysis, it is clear the Petitioner case is in the category of a person moving from one job to another. It is not analogous to the situation when a person selects individual coverage once he exhausts all other coverage. Therefore, the Commissioner concludes that the Petitioner is not required to exhaust his COBRA coverage before his pre-existing condition exclusion is waived. To do otherwise would require the Petitioner to pay out of pocket for dual health care coverage until the COBRA coverage expired or to delay eligibility for his group coverage. This would mean termination of the one person group coverage. This could lead to inferior future coverage or the reluctance of the employer to pay for future coverage. These are the types of problems HIPAA was intended to prevent. The Commissioner concludes that the Petitioner meets all the requirements for creditable coverage that are required to waive his pre-existing condition exclusion.

## **V ORDER**

The Commissioner reverses BCBSM's April 21, 2003, final adverse determination. BCBSM is required to waive the Petitioner's pre-existing condition exclusion and pay for his outpatient laboratory services provided on XXXXXXXXXX, XXXXXXXXX and XXXXXXXXXX.

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 the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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File No. 53861-001  
Page 6

Linda A. Watters  
Commissioner