

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. 102177-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 15th day of June 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 29, 2008, 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 (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on January 7, 2009.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on January 16, 2009.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Nongroup Comprehensive Health Care Benefit Certificate* (the certificate). The Commissioner 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 group health care coverage as an eligible dependent terminated on June 27, 2008, when her husband lost his job. He was offered COBRA at that time but initially did not take it because it was too costly. Her husband was advised to purchase COBRA coverage for one month and apply for BCBSM nongroup coverage and terminate the COBRA at the end of July. It was important for the Petitioner to have health insurance because she had been diagnosed with lung cancer in June 2008.

The Petitioner's coverage under BCBSM's *Nongroup Comprehensive Health Care Benefit Certificate* was effective July 20, 2008. She had cancer-related medical services in the months after her effective date. BCBSM denied reimbursement for these services because they were treatment of a pre-existing condition.

The Petitioner appealed BCBSM's failure to cover her cancer treatment. BCBSM held a managerial-level conference on December 11, 2008, and issued a final adverse determination dated December 15, 2008.

III ISSUE

Is BCBSM required to pay for the Petitioner's cancer treatment during the first six months of coverage under her nongroup certificate?

IV ANALYSIS

Petitioner's Argument

The Petitioner lost her health insurance when her husband lost his job. He was offered COBRA but because it was so expensive he looked into several other health insurance options. He turned to his home and auto insurance agent who advised him to apply for a family plan with BCBSM. At that time the Petitioner had been diagnosed with lung cancer.

The Petitioner's husband applied for BCBSM nongroup coverage around July 1, 2008. He says that the agent indicated that BCBSM probably would back date the coverage to July 1. However, the effective date of the coverage was July 20, 2008. The agent then advised him to purchase COBRA for one month.

The Petitioner's treatment for lung cancer was denied by BCBSM as treatment of a pre-existing condition. BCBSM will not waive the pre-existing condition exclusion because she only had COBRA coverage for one month. Once she was aware of this it was too late to reinstate the COBRA.

The Petitioner argues that she relied on the advice of her agent when she purchased the BCBSM coverage. Since she received incorrect information from her insurance agent she believes that BCBSM is required to cover all her care.

BCBSM's Argument

BCBSM says that the certificate covers most benefits beginning on the effective date of the contract. However, hospital and physician services for preexisting conditions are not covered during the first 180 days of coverage. The certificate says (page 1.6 – 1.7):

Most benefits are available on the effective date of your contract. However, hospital and physician services for preexisting conditions are not covered during the first 180 days of your coverage, beginning on the enrollment date.

The 180-day waiting period will not apply if:

- You have creditable coverage and meet the following:
 - There was no more than a 62-day break in your prior 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 only 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 creditable coverage to eliminate the preexisting waiting period. [Underlining added]

The certificate defines a preexisting condition as:

A condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date

BCBSM believes that there is no dispute that the Petitioner's lung cancer is a preexisting condition and that she did not exhaust her COBRA coverage. Therefore, any treatment for her lung cancer received within the first 180 days after her nongroup coverage was effective on July 20, 2008, is excluded from coverage.

The Petitioner indicated that her insurance agent advised her husband to cancel the COBRA after one month and that the BCBSM coverage should start on July 1. However, this agent's representation does not change the explicit language of either BCBSM's certificate or applicable state law. Further even if the effective date of the Petitioner's coverage was July 1, 2008, her treatment would still have been properly denied as due to a preexisting condition.

Commissioner's Review

The certificate explains that treatment for a preexisting condition is not covered during the first 180 days after the effective date of coverage, i.e., from July 20, 2008, through January 16, 2009. It is undisputed that the Petitioner had a preexisting condition since her lung cancer was diagnosed in June 2008. The Petitioner received treatment for her lung cancer during the first 180 days after the start of his non-group coverage. Therefore, it was care for a preexisting condition and not a covered benefit according to the terms of the certificate.

Both the certificate and the nongroup application form that the Petitioner was required to fill out explain that treatment for preexisting conditions is excluded for the first 180 days of coverage. The certificate and the application form also explain that the waiting period can be waived if COBRA coverage is elected and exhausted. The Petitioner acknowledged that she had not exhausted her COBRA coverage and BCBSM declined to waive the preexisting condition waiting period.

The Petitioner also says that an insurance agent misinformed her about her coverage.

Unfortunately, even if that is true, it cannot be the basis for a decision under the Patient's Right to Independent Review Act (PRIRA). Under PRIRA, the scope of the Commissioner's review is limited to determining whether BCBSM has correctly administered health care benefits under the terms and conditions of the applicable insurance contract and state law. The Petitioner must seek relief for alleged misrepresentation by an agent in another forum.

The Commissioner finds that BCBSM correctly applied the terms and conditions of the Petitioner's certificate when it denied coverage for her lung cancer treatment beginning on July 20, 2008, as treatment for a preexisting condition.

V
ORDER

BCBSM's final adverse determination of December 15, 2008, is upheld. BCBSM is not required to cover the Petitioner's lung cancer treatment for the first 180 days of her coverage since it was treatment for a preexisting condition and therefore not a covered benefit under the certificate.

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.