

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 118390-001

Humana Insurance Company

Respondent

Issued and entered
this 10th day of May 2011
by R. Kevin Clinton
Commissioner

ORDER

I. BACKGROUND

On December 2, 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.* The Commissioner reviewed the information and accepted the request on December 9, 2010.

The Commissioner notified Humana Insurance Company of the external review and requested information used in making its adverse determination. The Office of Financial and Insurance Regulation received the information from Humana on December 10, 2010.

The issue here can be decided by applying the terms of the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

The Petitioner is covered under a Humana certificate of insurance with an effective date of July 1, 2010. Petitioner applied for the coverage on May 20, 2010. The benefit plan is issued to an association called "XXXXX." Association-based benefit plans are considered individual coverage under Michigan and federal law. See section 3406f(2) of the Michigan Insurance Code, MCL 500.3406f(2).

Prior to July 1, 2010, Petitioner received health care benefits under a self-funded plan created by XXXXX, a Pontiac, Michigan hospital where his wife was employed. Coverage under the XXXXX plan began August 1, 2009 and terminated on June 30, 2010 when his wife's employer discontinued the health plan.

On June 25, 2010, Petitioner was seen in the emergency room at Doctors' Hospital where a CT scan revealed the presence of a kidney stone. The emergency room care was covered by the XXXXX plan.

On July 1 and August 16, 2010, Petitioner underwent follow-up surgical treatment to remove the kidney stone. Claims were submitted to Humana which denied coverage, ruling that the care constituted treatment of a pre-existing condition.

The Petitioner appealed the denial through Humana's internal grievance process. Humana affirmed its decision in its November 6, 2010¹ final adverse determination.

II. ISSUE

Was Humana correct when it ruled that the July 1 and August 16 treatment of Petitioner's kidney stone was treatment of a pre-existing condition?

III. ANALYSIS

Petitioner's Argument

Petitioner says he did not have a pre-existing condition when he applied for health insurance with Humana in May 2010, or in the previous three years. He says he changed his effective date of coverage for Humana from June 1 to July 1, 2010 because he discovered that his XXXXX plan was expiring on June 30 rather than May 31.

Respondent's Argument

In its November 6, 2010 final adverse determination Humana wrote:

We were unable to approve your appeal to allow benefits for the claims submitted by XXXXX and XXXXX for the services you received on July 1, 2010, and August 16, 2010. It has been determined that the services were related to treatment of a pre-existing condition. Your policy does not cover any pre-existing conditions for the first 12 months. . . .

The records we received from XXXXX indicate that you were seen in the emer-

1. Humana issued an amended final adverse determination on December 14, 2010, after Petitioner had filed his request for external review with OFIR. The amended adverse determination is not materially different from the original November 6, 2010 determination.

gency room on June 25, 2010, for complaints of left flank pain. The CT revealed that you had a stone obstructing the left distal ureter causing moderate hydronephrosis.

Your policy defines a pre-existing condition as any disease or illness that was diagnosed or treated within the six month period to your effective date. Therefore, because you were treated for these conditions during the six months prior to your effective date, they are considered pre-existing.

Your policy became effective on July 1, 2010, so the pre-existing condition limitation will expire on June 30, 2011. Until that time, there are no benefits available for any services or treatments relating to these conditions.

Commissioner's Review

Humana's denial of coverage is based on the policy's pre-existing condition limitation which is described on page 29 of the policy:

a. What is a pre-existing condition?

A sickness or bodily injury and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a healthcare practitioner or prescription drugs were prescribed during the six month period immediately prior to the covered person's effective date, regardless of whether the condition was diagnosed or not diagnosed.

b. Pre-existing condition limit

We will not pay benefits for services rendered for pre-existing conditions or complications of a pre-existing condition for a period of 12 months from the effective date of the covered person unless those conditions were fully disclosed on the enrollment form for this Certificate and benefits relating to those conditions are not specifically excluded.

Any condition not disclosed on the enrollment form may result in rescission or reformation of this Certificate and/or modification of benefits. . . .

Pre-existing condition limitation provisions are permitted in individual coverage by section 3406f(1)(a) of the Michigan Insurance Code, MCL 500.3406f(1)(a) which provides:

(1) An insurer may exclude or limit coverage for a condition as follows:

(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

It is not in dispute that the Petitioner sought emergency treatment June 25, 2010 and was diagnosed with a kidney stone. This was a week before the effective date of his Humana policy. Petitioner's treatment to remove the kidney stone took place on July 1 and August 16, 2010 which is within one year of the diagnosis of that condition

The Commissioner finds Humana's application of the pre-existing provisions to Petitioner's July 1 and August 16, 2010 services was consistent with the terms and conditions of the certificate and Michigan law.

IV. ORDER

The Commissioner upholds Humana's November 6, 2010 final determination. Humana is not required provide coverage for the medical treatment Petitioner received on July 1 and August 16, 2010.

This is a final decision of an administrative agency. 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. See MCL 550.1915(1), made applicable by MCL 550.1952(2). 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.

R. Kevin Clinton
Commissioner