

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. 146341-001

PHIC Insurance Company,

Respondent.

Issued and entered
this 25th day of March 2015
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 17, 2015, ██████████ (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 health care benefits under an individual policy issued by PHIC Insurance Company. The Director notified Priority Health of the external review request and asked for the information it used to make its final adverse determination. Priority Health furnished information for the review on February 18, 2015.

After a preliminary review of all the material, the Director accepted the Petitioner's request on February 24, 2015.

The Director also assigned the case to an independent review organization which provided its recommendation on March 10, 2015.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in Priority Health's *MyPriority Individual PPO Insurance Policy* (the policy). Her coverage under the policy was effective on December 31, 2013, which Priority Health says was also her enrollment date. The policy has a

pre-existing condition limitation.¹

On March 2, 2014, the Petitioner was taken by ambulance to the emergency department of ██████████ Hospital. According to the hospital report, she complained of abdominal pain that “radiates to right shoulder and arms.” She was evaluated and treated, and released with instructions to follow up with her primary care physician for further treatment. Her diagnosis at the time of discharge was related to cholelithiasis (gallstones).

The Petitioner received follow up treatment for this condition from various providers through March 28, 2014. Priority Health denied coverage for the emergency room services and follow up care, saying it was for the treatment of a pre-existing condition and therefore excluded from coverage under the terms of the policy.

The Petitioner appealed the denials through Priority Health’s internal grievance process. At the conclusion of that process, Priority Health issued a final adverse determination dated December 18, 2014, affirming its denial. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did Priority Health correctly deny coverage for the Petitioner’s medical services from March 2 to 28, 2014, because they were for the treatment of a pre-existing condition?

IV. ANALYSIS

Pre-existing condition limitations in individual policies are authorized by section 3406f of the Michigan Insurance Code:

(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. MCL 500.3406f.

The Petitioner’s policy has a similar provision in “Section 6. Limitations” (p. 33):

A. Pre-Existing Condition Exclusion

¹ The preexisting condition waiting period in the certificate was permissible at the time the Petitioner enrolled for coverage with Priority Health even though such provisions are now generally prohibited by the federal Patient Protection and Affordable Care Act.

This provision does not apply to anyone under the age of 19.

Benefits will be excluded for each Illness or Injury or condition not disclosed on your application, for which, during the six month period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, “treatment” includes the use of prescription drugs. Genetic information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to the genetic information.

This Pre-Existing Condition exclusion will apply until the end of the twelve-month period beginning on your effective date under this Policy.

“Pre-existing condition” is defined in the policy (p. 47) as:

An Illness, Injury or condition not disclosed on your application, for which, during the six month period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, “treatment” includes the use of prescription drugs. Genetic information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to the genetic information.

The language of the policy differs from the language in section 3406f of the Insurance Code in that the Insurance Code does not define as pre-existing only those conditions not included in an insurance application. Priority Health’s decision to include that requirement is permissible here because it is less restrictive than section 3406f, i.e., it impliedly says that conditions disclosed on an application would not be subject to the pre-existing condition limitation.

The policy provision also defines the “look back” period as “the six month period prior to [the] effective date” while section 3406f says it is the “6 months before enrollment.” However, that difference is not material because the enrollment date and the effective date are the same in this case.

According to the policy, the treatment the Petitioner received in March 2014 would not be covered if it was for a condition for which “medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional” during the look back period and if the condition was not disclosed on the application for insurance.

The Petitioner received advice and diagnosis related to gallstones during her office visit on December 5, 2013, with [REDACTED], who ordered an ultrasound because of suspected gallbladder disease. That office visit occurred during the look back period. Therefore, Priority Health contends that the care the Petitioner received in March 2014 for gallstones was for a pre-existing condition. The independent review organization (IRO) that was assigned to review this

case implicitly agreed in its report that the treatment in March 2014 was related to the diagnosis the Petitioner received in December 2013:

There is no disagreement that the enrollee had symptoms attributable to her underlying gallstones which culminated in surgery in March, 2014. There is no disagreement that the first presentation to a medical provider for this complaint was on December 5, 2013, where an ultrasound was ordered to evaluate specifically for gallstones.

Under the facts above, the Director concludes that Priority Health correctly denied coverage for the care in March 2014 as treatment of a pre-existing condition under the terms of the policy because the Petitioner received advice about gallstones in the six-month period prior to the effective date of coverage on December 31, 2013, and the condition was not disclosed in the application. The application for insurance was submitted online on December 12, 2013, and was approved on December 16, 2013. Priority Health pointed out that the Petitioner's husband answered "no" to question #16 on the application:

Has anyone applying for coverage had any testing, surgery, treatment, therapy, medications, or hospitalization recommended or advised and not yet completed?
Or treatment for any other condition not already disclosed on this application?²

The Director understands why the gallstone diagnosis in December 2013 may not have been included in the application for insurance since it occurred very close to the time the application was submitted. Nevertheless, the policy contains no exception to the requirement that conditions be disclosed on the application to avoid the pre-existing condition limitation.

This case was assigned to an IRO for a recommendation, which the IRO submitted on March 10, 2015. The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, in a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). In this case, the Director rejects the IRO's conclusion that the "medical services for gallbladder issues beginning March 2, 2014 were not related to a pre-existing condition."

The IRO's recommendation is based on the premise that a valid application for insurance was submitted in November 2013, before the Petitioner had seen ██████████ in December 2013, and therefore it was not possible for her to have included the diagnosis of gallstones on the application. However, the Director could find nothing in the record to support that argument. Although the Petitioner's husband did say on his Priority Health appeal form dated October 27,

² The Director notes that the answer was also "no" to question #3 on the application: "Any digestive system disorders including diseases of the pancreas, liver or gallbladder, . . . ?"

2014, that he “signed the paperwork for enrollment” in November 2013, no documents substantiate that assertion.

The only evidence in the record of an application is the one that was submitted online on December 12, 2013, and approved on December 16, 2013. The Petitioner herself acknowledged that the application was submitted at that time; in her request for an external review she said, “Enrolling with Priority Health and submitting the application took place between the office visit for physical 12/5/2013 and the office visit to discuss the results and findings which took place around 12/22/2013.”

The Director rejects the IRO report and finds that Priority Health correctly denied of coverage for the Petitioner’s gallbladder medical services beginning March 2, 2014, as treatment of a pre-existing condition.

V. ORDER

The Director upholds Priority Health Insurance Company’s December 18, 2014, 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.

Annette E. Flood
Director

For the Director



Randall S. Gregg
Special Deputy Director