

Preexisting Conditions

Overview

The importance of the preexisting condition provision has been greatly diminished by HIPAA with the waiver of such provision by a certification of prior coverage. However, many employees do enroll without such waiver and the typical probational in such instances, is 18 and not 12 months. The preexisting provision has increased in significance for this reason.

Meaning Of Care and Treatment

Medical care or treatment is the professional care and attention which the physician furnished to the covered person. An indication for invoking the pre-existing condition limitation is where the covered person is receiving professional services or medical supply items under direct physician supervision. This includes services of auxiliary personnel employed by the physician and working under such physician's supervision, such as physician's assistants, nurses, technicians, therapists, and other aides. A covered person is also receiving medical care or treatment by a physician when during the course of diagnosis or treatment he is self-administering drugs and biologicals not requiring direct physician's supervision although recommended and prescribed by the physician.

Reason for the interpretation of the phrase *medical care or treatment* is that, in administering the preexisting condition limitation, situations were confronted involving medical anomalies, both congenital and acquired, in which covered person would not be eligible to receive benefits due to a lifetime medical regimen not necessarily requiring periodic visits to a physician. A common example of this is the diabetic, who, after medical regimen is established by the attending physician, self-administers his prescribed insulin medication.

Evaluation of Possible Preexisting Condition

These aspects should be considered:

- Diagnosis for all charges submitted
- Knowledge of conditions, their nature and severity including symptoms plus type and frequency of treatment at different stages of development, relationship of multiple conditions.
- Characteristics of preexisting conditions: long standing and incurable, constant management required, chronic and recurrent, not in remission or recovery.

- Diagnoses frequently determined to be preexisting conditions in the course of claim investigation.
- Diagnoses which are generally not preexisting: accidents, acute conditions.
- Are medical services, supplies or expenses incurred within the pre-existing period?

Investigation of a Preexisting Condition

The following consideration and items are needed:

- *Completed Claim Form*
 1. Names and address and dates of medical treatments – include family or primary as well as referred physicians.
 2. Description of medical condition.
- *Physician Records*
- *Hospital Records*
- *Claimant Inquiry.*

Send claimant a delay letter informing the claimant of the reason for the processing delay.

No Loss/No Gain

The terms *no loss/no gain* or *no loss of coverage* refer to the benefits handling which deals with situations where an employer transfers the group plan from one arrangement to another. The intentions of the no loss/no gain concept is that, aside from the actual changes in plan provisions, employees will not gain or lose any *earned rights* due to circumstances which would not have occurred without an arrangement change. This policy may be stated formally in the plan document or handled administratively.

This does not mean participants cannot gain or lose benefits for newly provided benefits. It does mean that participants will not have certain earned rights eliminated.

For examples, re-satisfying a probationary period, a deductible, an out-of-pocket limit or having a new preexisting condition imposed would be in violation of no loss/no gain rules.

It is contrary to the management of group plans that there be a gap in coverage. If Plan X terminates on October 31, Plan Y as its replacement, should be effective November 1. This underlying principle will guide the examiner in determining no loss/no gain.

No participant rights based upon prior service shall be reduced - or improved - when a plan arrangement is changed.

Relevant Court Decisions

Employee was regularly taking heart medicine using a refillable prescription. On July 10, he changed pharmacists and had to have a fresh physician authorization. On July 25, he became a plan participant. Did the physician call to the pharmacist confirming the refill constitute medical treatment? Jury said yes and appellate court held claim was pre-existing.

Prior to issue, insured had possibly a sinus blockage but no infection; an infection developed after issue. Court held benefit was payable.

Participant had a long history of arteriosclerosis. One month before issue, participants arteriogram was normal. Shortly after issue, surgery was done to correct an insufficiency of the right carotid artery. Court held pre-existing did not apply.

Participant clearly had preexisting heart condition. After issue, there was a hospitalization but no medical evidence indicated it was for heart trouble. Participant subsequently was hospitalized for a heart condition and such benefit denied citing pre-existing. Court held first that paying hospitalization did not estop insurer from denying the second hospitalization.

Participant was admitted to the hospital as a covered employee and signed a blank assignment form. Benefit was subsequently denied as a preexisting condition. Evidence given the court showed that participant did not intend to assign benefits. The hospital failed to have any standing to sue in this instance.

The no loss, no gain rule applies where a group master policy is switched. It does not apply when an individual changes from one employer to another.

Policy did not define treatment or diagnosis. Insured was diagnosed as having condition "X" on December 27 with no treatment; coverage become effective January 1 and was treated surgically on January 3. Insurer claimed preexisting. Court held it was not preexisting (treatment absent), but did not hold insured to be arbitrary or capricious in denial.

Heart attack of 1980 was contested for disability claim due to a pre-policy heart attack in 1975. The insured made a prime facie case showing the two were not connected.

Insured had received care and treatment for tonsils before effective date. Claim for T&A denied because of such preexisting facts. The insured wanted the claim paid because the need for surgery arose after policy issue. Court held otherwise; that is, it was a valid denial.

Child saw a physician for brief diagnostic examination relative a cleft palate. Employee was in the treatment free period of the preexisting provision. Such did not constitute treatment within the meaning of the preexisting provision.

Preexisting condition was cervical disc syndrome. After coverage, claim for peripheral neuritis of left ulna nerve was made. Court held the claim was deniable.

Condition requiring post-issue surgery was present prior to policy issue. Court held clearly preexisting condition.

Heart condition was preexisting; post-issue claim of hardening of arteries. Court held preexisting condition exclusion would apply.

Insured had long history of progressive lipid protienosis; after policy issue there developed a perforated ulcer. Court held ulcer was preexisting.

Three days after coverage was effective, uterine bleeding began which developed to be a tumor. The tumor was surely preexisting but no care, treatment, diagnosis was shown to indicate preexisting. Court held insurer liable.

Accident result was made worse by pancreatitis, a preexisting condition. Court held that accident claim was payable and ignored the preexisting pancreatitis. Insurer held liable.

Employee had arteriosclerotic cardiovascular disease prior to effective date. Employee believed the medical treatment was preventive - and claimed no knowledge of the disease. Court held that a lack of understanding was of no moment - preexisting rules would apply and claim was properly denied.

Ulcer was established as preexisting condition. Operation occurred shortly after issue for bleeding ulcer. Court held claim not payable.

Where policy had the preexisting condition stated but booklet did not, insurer lost its right of defense.

Court held that a congenital preexisting condition is not a preexisting condition at all. Where preexisting provision omitted from the booklet, insurer lost its defenses thereto. Long history of poor health (hysterectomy, leg injury, e.g.) were clearly preexisting; hospitalization shortly after, coverage effective date of bronchitis. Court held insurer liable. While insurer lost on preexisting issue, there was no punitive damages because preexisting was arguable.

Child hospitalized with a \$1,000,000 cap for mental and nervous. While hospitalized, the cap was reduced to \$25,000 by changing plans and carriers. Court held such reduction was ineffective so long as the preexisting condition continued.

Insurer denied a cancer claim due to preexisting conditions. Participant's denied both knowledge and treatment thereof. Failing clear establishment of diagnosis, court held for the participant. Lower court's strong punitive award was overturned on appeal, however.

Plan excluded preexisting conditions, the symptoms of which were manifest before policy issuance. Such was the case with cancer treatment. Court held for the insurer.

The no loss, no gain provision was to protect existing people when a replacement plan was installed. It was not to protect a person with a health problem who switched employers.

Participant had hypertension and treatment as a preexisting condition. Plan denied bypass surgery as a preexisting condition. Court held that there was not sufficient tie-in.

Participant diagnosed as having fibroid tumor prior to coverage. A hysterectomy done shortly after issue was turned back as a preexisting claim. Court held the claim was payable.

Preexisting care was for acute gastroenteritis with additional presence of gallstones. Surgery after coverage effective date was for inflammation of the gall

bladder. Court held the surgery resulted from new condition and that surgery should be paid.

Replacement policy had a preexisting condition which applied to present plan participants. Employer failed to notify employees of this significant plan cutback. Plan was contributory. Court held that employer had a duty to notify the employee of this cutback. Failing to do so, employer had to pay a preexisting claim.

Care and treatment for esophageal varices was pre-coverage. Surgery for such varices was properly a denial as a preexisting condition.

Insurer lost defense of preexisting where the pre-coverage conditions were:

- Kidney and bladder infection
- Hernia of the esophagus.

The post-coverage conditions were:

- Cystitis
- Pyelonephritis
- Gastritis
- Reflux esophagitis.

Plan clearly would have excluded a preexisting condition. Where booklet had not been furnished and where insurer had assured the participant that coverage would be provided, court held insurer negligent and required that benefit be paid - even though preexisting.

Participant had a preexisting bad back but had an accident which was worsened due to the preexisting back problem. Insurer incorrectly denied the claim. Court held that benefit was payable but that insurer was not capricious in its denial.

While being examined for hypertension, participant asked the doctor to look at a mole, recently turned a different color. Doctor referred her to a dermatologist. She was the cardiologist pre-issue; the dermatologist post-issue. Melanoma later required surgery. Visit to cardiologist constituted care and medical treatment for preexisting purposes.

Accident after coverage began caused a flare-up in a pre-existing arthritic condition. Court held benefit should be paid.