STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

WILLIAM STEVE LANG,	)	
	)	
Petitioner,	)	
	)	
vs.	)	CASE NO. 93-3729
	)	
DEPARTMENT OF MANAGEMENT SERVICES, DIVISION OF STATE EMPLOYEES' INSURANCE,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

On August 31, 1993, a formal administrative hearing was held in this case in Clearwater, Florida, before J. Lawrence Johnston, Hearing Officer, Division of Administrative Hearings.

APPEARANCES

For Petitioner: William Steve Lang, pro se
2233 Willowbrook Drive
Clearwater, Florida 34624

For Respondent: Augustus D. Aikens, Jr., Esquire
Department of Management Services
2002 Old St. Augustine Road, B-12
Tallahassee, Florida 32301-4876

STATEMENT OF THE ISSUE

The issue in this case is whether the Petitioner's health care expenses for a condition diagnosed on August 26, 1992, should be covered under his state employees' group health insurance, or whether coverage for the diagnosis should be denied under the pre-existing conditions limitation of the plan.

PRELIMINARY STATEMENT

On or about April 22, 1993, the Respondent, the Department of Management Services, Division of State Employees' Insurance (DSEI), notified the Petitioner, William Steve Lang, that it was denying the Petitioner's claim under his state employees' group health insurance for health expenses relating to a condition diagnosed on August 26, 1992, on the ground that they were for a pre-existing condition not covered by the health insurance plan.

The Petitioner requested formal administrative proceedings under Section 120.57, Fla. Stat. (Supp. 1992), and the matter was referred to the Division of Administrative Hearings on July 1, 1993. By Notice of Hearing issued on August 2, 1993, final hearing was scheduled for August 31, 1993, in Clearwater, Florida.

At the final hearing, the Petitioner testified in his own behalf and called one additional witness. He also had Petitioner's Exhibits 1 through 7 admitted in evidence. The Respondent called one witness and had Respondent's Exhibits 1 through 5 admitted in evidence.

Neither party ordered the preparation of a transcript of the final hearing, and the parties were given ten days in which to file proposed recommended orders. Explicit rulings on the proposed findings of fact contained in the parties' proposed recommended orders may be found in the attached Appendix to Recommended Order, Case No. 93-3729.

FINDINGS OF FACT

1. Before being hired by the University of South Florida (USF), St. Petersburg campus, to start August 1, 1992, the Petitioner taught college in Georgia. At his college in Georgia, the Petitioner was insured under a private employee group health insurance policy and had the option, under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), to maintain coverage under that insurance.

2. The Petitioner visited his new campus on or about May 22 and June 28, 1992. While there in June, he filled out various personnel forms required in advance of his start date. Possibly because the chief USF personnel officer at the St. Petersburg campus was on vacation, he was not told about the available state employees' group health care plans or the requirement that, if he wanted to enroll in one before the next open enrollment period, he had to select one of within 31 days of his starting employment date.

3. The Petitioner started work, as scheduled, on August 1, 1992. He first pay check was dated August 21, 1992, and covered the two-week pay period from July 28 through August 13, 1992. There were no deductions from the Petitioner's pay for health insurance, as he had not enrolled in any state employees' group health plan.

4. On August 20-21, 1992, the Petitioner participated in a new faculty orientation program during which he became aware of the state employees' group health care plans and the requirement that he enroll within 31 days of beginning employment if he wanted to enroll in one before the next open enrollment period.

5. Before taking any steps to enroll in any of the state employees' group health care options, the Petitioner took ill on or about August 24, 1993. His symptoms were new to him and included chest pain and rapid heart rate. The next day, August 25, 1992, he went to see the chief personnel officer at USF, St. Petersburg, to discuss his options and enroll in one of them. (At least by this time, he had available for his review an informational brochure summarizing the state employees' group health insurance plan.) He chose the state employees' group health insurance plan and enrolled.

6. The personnel officer filled out the enrollment forms for coverage to begin September 1, 1993. In order to obtain a September 1st effective date of coverage, it was necessary to "triple deduct" employee contributions towards the insurance premiums in the Petitioner's next pay check so that the premium for coverage in September would be paid. (Normal deductions out of September's pay checks would go to pay the premiums for coverage in October, 1992.)

7. The Petitioner discussed with the personnel officer whether it was possible to get an earlier effective date by paying the first month's premium by personal check. The personnel officer advised him that USF does not accept personal checks for this purpose and that, in any event, no effective date earlier than September 1, 1992, could be obtained in this way.

8. The next day, August 26, 1992, the Petitioner went to see a physician who was on the state employees' group health insurance preferred provider plan for diagnosis and treatment of his condition. Not surprisingly, since the Petitioner had submitted his enrollment forms through his personnel office only the day before, the physician was unable to verify coverage, and the Petitioner paid the fees for services out-of-pocket. He anticipated that he would be reimbursed by his new insurance, or that his out-of-pocket expenditures would serve to fulfill, in whole or in part, the deductibles under his new insurance.

9. On or about September 2, 1992, the Petitioner returned to his physician for additional health care services in connection with his condition. (Ultimately, it was determined that the Petitioner suffered from mitral valve prolapse and supraventricular tachycardia that was successfully treated with beta blocker therapy.) The physician's office still could not verify insurance coverage, and the Petitioner again paid the fee for services in cash. The Petitioner discussed the situation with the USF, St. Petersburg, chief personnel officer, and they decided that the information concerning the Petitioner's enrollment had not been entered in the computer system yet.

10. Later in September, 1992, the Petitioner again returned to his physician for additional health care services in connection with his condition. The physician's office still could not verify insurance coverage. At the very end of September, the Petitioner received an explanation of benefits (EOB) from Blue Cross Blue Shield (BCBS), the plan administrator, indicating that the Petitioner's contract of insurance could not be located.

11. The Petitioner again went to discuss the matter with the USF, St. Petersburg, chief personnel officer. She sent DSEI a memorandum, with the Petitioner's enrollment form attached, asking for verification that the Petitioner's coverage was in effect. Meanwhile, the Petitioner decided to postpone further health care services until he received a response from DSEI.

12. Later in October, 1992, the Petitioner was advised by his physician's office that verification of the Petitioner's coverage had been received. The Petitioner returned to the physician's office for additional health care services in connection with his condition on or about October 9 and 19, 1992.

13. At approximately the end of October, 1992, the Petitioner received an EOB form from BCBS, dated October 25, 1992, advising the Petitioner and his physician that BCBS needed and was awaiting verification, in the form of office records and the history and physical, of the condition for which the Petitioner was treated.

14. On or about October 30, 1992, the Petitioner scheduled an appointment with the USF, St. Petersburg, chief personnel officer to discuss the Petitioner's insurance options. Open enrollment closed the next day, and the Petitioner had to decide whether to keep his coverage or switch to a health maintenance organization, or seek coverage under his wife's employee group insurance coverage and possibly drop his own insurance. He chose to keep his state employees' group health insurance.

15. In early November, 1992, the Petitioner received another EOB form from BCBS, dated November 4, 1992, advising the Petitioner and his physician that BCBS still was waiting for additional information from the Petitioner's physician's office in connection with the services provided on September 2, 1992.

16. At the end of December, 1992, the Petitioner received a statement from his physician's office indicating that DSEI was denying all of the Petitioner's claims as "pre-existing."

17. In pertinent part, the state employees' group health insurance plan lists under its "limitations":

> For any accident or illness for which an insured received diagnostic treatment or received services within three-hundred and sixty-five (365) consecutive days prior to the effective date of coverage, no payment will be allowed for services related to such accident or illness which is received during the three hundred and sixty-five (365) consecutive days subsequent to the effective date of coverage; however, covered services related to such accident or illness which are received after three hundred and sixty-five (365) consecutive days of coverage are covered by the Plan.

A verbatim reproduction of this limitation is included in the informational brochure which the Petitioner was provided and reviewed no later than August 25, 1992.

CONCLUSIONS OF LAW

18. F.A.C. Rule 60P-2.004(1) provides:

> The effective date of coverage requested by the employing agency for enrollment or changes in coverage in the Health Plan by an employee shall always be the first day of a month, subject to the following:
> (a) Subject to the requirements of subsection (2), the requested effective date shall be no later than the first day of the month for which a full month's premium may be deducted using single deductions based upon the employee's signature date on the New Enrollee or Change of Information form.
>
> (b) The requested effective date shall be no earlier than the first day of the month following the employee's signature date on the New Enrollee or Change of Information

> form; however, in no case shall such effective date be prior to or on the employee's employment date.

Under this rule, the earliest effective date the Petitioner could have received for coverage under the state employees' group health insurance plan was September 1, 1992.

19. Under the limitations of the plan, the Petitioner would not be covered for his August 26, 1993, diagnosis until September 1, 1993.

20. The Petitioner has complained about various things in connection with his experiences with the state employees' group health insurance plan, DSEI and BCBS. These complaints include the alleged deficient method of notification to employees that their coverage is in effect and alleged delays, beyond alleged BCBS policy guidelines, in notifying the Petitioner that his claims were being denied. He apparently hopes that these complaints will support an argument that his claims should be paid, but they do not.

21. The Petitioner also claims that, had he been timely notified that he was not covered, he could have taken other steps to secure coverage, such as extend coverage under his previous private employees' group health insurance policy under the terms of COBRA, switch to a health maintenance organization, or seek coverage under his wife's employee group insurance coverage. Essentially, he is arguing that DSEI should be estopped from denying coverage.

22. The Petitioner's estoppel argument fails for at least one essential reason. The facts indicate that the essential reason why the Petitioner made less-than-optimum decisions with regard to his health insurance coverage was that he (and, apparently, his physician) did not comprehend the pre-existing conditions limitation of the state employees' group health insurance plan. Throughout the fall of 1992, he seemed to be operating under the assumption that, once it was verified that coverage was effective, his claims would be paid. Only some time after he received notification in December, 1992, that DSEI was denying his claims under the pre-existing conditions limitation did the Petitioner begin to focus his efforts on getting an earlier effective date of coverage established. The Petitioner has not claimed, nor is there any evidence, that DSEI made misrepresentations that somehow misled the Petitioner regarding the pre-existing conditions limitation.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Respondent, the Department of Management Services, Division of State Employees' Insurance, enter a final order denying the Petitioner's claims.

RECOMMENDED this 24th day of September, 1993, in Tallahassee, Florida.

J. LAWRENCE JOHNSTON
Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of September, 1993.

APPENDIX TO RECOMMENDED ORDER, CASE NO. 93-3729

To comply with the requirements of Section 120.59(2), Fla. Stat. (1991), the following rulings are made on the parties' proposed findings of fact:

Petitioner's Proposed Findings of Fact.

Legal Argument 1

Understanding

1. Accepted as to the earlier treatment, and incorporated; rejected as to the later treatment.
2. Rejected as not proven and contrary to the facts found. (Both the "turn-around" and the insurance card provided this information. It also could have been verified by DSEI on telephone or written request.)
3. Accepted and incorporated.
4. Accepted that the information was disseminated, but subordinate and unnecessary. Rejected that DSEI "discounted" it.
5. Rejected that the provider "paid partial claims." Otherwise, accepted and incorporated to the extent not subordinate or unnecessary. (Once basic coverage was verified, the provider processed the claims, but the provider made no determination as to the pre-existing conditions limitation, nor did the provider have any authority to do so.)
6. Rejected as not proven that none of the information was "available to new employees." (Some is distributed to new employees, and some is available in personnel offices upon request.)
7. Accepted but subordinate to facts contrary to those found. (It was not proven and was not found that the triple deduction occurred during the first two weeks of August. She may have meant to say September.)
8. Accepted but subordinate and unnecessary. (The term "performance date" is ambiguous.)

Consideration

1.-2. Rejected as not proven and contrary to facts found. (Enrollment was effective September 1, 1992, as requested by the Petitioner. The Petitioner was unable to verify the enrollment date until October, 1992. The Petitioner got

coverage effective September 1, 1992, subject to the plan's pre-existing conditions limitation (among others), a concept the Petitioner never fully understood.

Performance

1. Rejected as not proven and contrary to facts found. See above.
2. Rejected as not proven and contrary to facts found. (The first claims were paid in cash, to be applied to the deductible. The EOB dated October 25, 1992, first raised the question of the pre-existing conditions limitation by requesting verification of the condition being treated on September 18, 1992.) Also, subordinate and unnecessary.
3. Accepted but subordinate and unnecessary. (The provider is not authorized to approve claims and was assuming coverage without considering the pre-existing conditions limitation.)
4. Accepted (for a September 1, 1992, effective date) and incorporated.

Legal Argument 2

(The Petitioner's argument, that the DSEI defense is "mute," falls on deaf ears.)

1.-2. Rejected as not proven. (The typed form was not placed in evidence.) Also, subordinate and unnecessary.
3. Accepted but subordinate and unnecessary.
4. Rejected as not proven. (The typed form was not placed in evidence.) Also, subordinate and unnecessary.
5. Rejected as not proven. Also, ambiguous, subordinate and unnecessary.

Legal Argument 3

1. Rejected as not proven. Also, subordinate and unnecessary.
2. Cumulative. See above.
3. Accepted but subordinate to facts contrary to those found, and unnecessary. (The provider has no authority to determine claims and obviously, like the Petitioner, did not have a full comprehension of the pre-existing conditions limitation in the state plan.)
4. Rejected as not proven and contrary to the greater weight of the evidence.
5. Cumulative. See above.
6. Rejected as not proven and contrary to the greater weight of the evidence. As to a.), USF policies interfered with the operation of the insurance program in that respect; as to b.), cumulative.
7. Cumulative. See above.

Respondent's Proposed Findings of Fact.

1. Rejected as contrary to facts found. (The start date was August 1, 1992.)
2.-7. Accepted and incorporated to the extent not subordinate or unnecessary.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit to the Department of Management Services written exceptions to this Recommended Order. All agencies allow each party at least ten days in which to submit written exceptions. Some agencies allow a larger period within which to submit written exceptions. You should consult with the Department of Management Services concerning its rules on the deadline for filing exceptions to this Recommended Order.