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Health Insurance Market Reforms: Pre-Existing Condition Exclusions

Overview

What is a pre-existing condition?

Pre-existing conditions are medical conditions or other health problems that existed before the date of an individual's enrollment in a health insurance plan. Such conditions include chronic conditions like asthma and heart disease, as well as shorter-term medical conditions such as back injuries or pregnancy.

Insurers pursue multiple strategies to mitigate the cost of covering enrollees with pre-existing conditions. Insurers can [refuse to cover](#) individuals with a pre-existing condition. Alternatively, an insurer might issue a policy, but charge that individual [higher premiums](#) based on his or her pre-existing condition. The insurer can also impose a **pre-existing condition exclusion** on the policy, which allows the insurer to refuse to cover any costs associated with care for a pre-existing condition permanently or for a period of time.

How are pre-existing condition exclusions regulated under current law?

Pre-existing condition exclusions are currently regulated under both federal and state law. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Genetic Information Non-Discrimination Act, and Affordable Care Act (ACA) impose restrictions on insurers' ability to limit the coverage of pre-existing conditions. In addition to minimum federal requirements, some states have additional protections for individuals and employees of small businesses with pre-existing conditions.

Individual Market. In the individual market, HIPAA prohibits insurers from imposing pre-existing condition exclusions on certain individuals when they enroll in coverage. In order to qualify as a HIPAA-eligible individual, a person must 1) have had at least 18 months of prior coverage, not interrupted by a gap of more than 63 consecutive days; 2) have exhausted any available continuation coverage, such as COBRA; 3) not be eligible for new group coverage or Medicare; and 4) have had their most recent coverage in a group health plan. However, even if a person meets all of the HIPAA requirements, most states do not limit the premium they can be charged because of their pre-existing condition.

Because there are no federal limits on pre-existing condition exclusions for adults not eligible for HIPAA, insurers can exclude a pre-existing condition from coverage unless state law restricts their ability to do so. While some states have passed laws to protect individuals against pre-existing condition exclusions, these laws vary. For example, some states prohibit insurers from using **elimination riders** in the individual market. An elimination rider is a provision in the policy that allows an insurer to permanently exclude coverage for any pre-existing condition disclosed at the time of application.

Many states have also passed laws to limit the length of time insurers may **look-back** into an applicant's medical history to screen for pre-existing conditions. In these states, look-back periods can range from 3 to 60 months. Some states impose **maximum exclusion periods** to limit the number of months that an insurer can refuse to pay for treatment of a pre-existing condition. In these states, this maximum exclusion period can range from 6 to 36 months from the date of coverage. In some states, exclusion periods can be reduced if a person had prior health coverage without a significant lapse in that coverage. And some states place no limits on either look-back periods or maximum exclusion periods in the individual market.

Although HIPAA adopts a definition of pre-existing condition in the group market, there is no similar definition in the individual market, and states vary in the way they define this term. Some states have adopted an **objective standard**, which counts only those conditions for which someone actually received medical advice, diagnosis, care or treatment prior to enrollment as a pre-existing condition. Other states have adopted a broader **prudent person standard**, which allows insurers to count as pre-existing those conditions that were never diagnosed, but caused symptoms for which an ordinarily prudent person would have sought medical advice, care, or treatment. Still other states do not define this term or grant insurers the discretion to define it themselves.

In addition to the requirements of HIPAA and state law, the Affordable Care Act (ACA) prohibits new plans in the individual market from imposing pre-existing condition exclusions on children under the age of 19, and the Genetic Information Non-Discrimination Act (GINA) prohibits insurers from excluding a pre-existing condition because of genetic information in the absence of a diagnosis of a condition.

Small Group Market. HIPAA's rules are more protective for coverage in the small group market than in the individual market. Under HIPAA, small group insurers can impose a look-back period of no more than six months for pre-existing conditions; any medical care or treatment received prior to this six-month period falls outside the look-back period and cannot be excluded from coverage. HIPAA's six-month look-back period is a minimum standard, and a number of states have eliminated or further reduced this period. HIPAA also limits the maximum exclusion period in the small group market to 12 months, although individuals may face an exclusion period of 18 months if they sign up late for their group health plan. HIPAA provides credit for prior coverage as well, meaning that exclusion periods are reduced if a person had prior health coverage. In order to qualify for such credit, the individual must not have allowed more than 63 days to lapse in between periods of coverage. Finally, HIPAA adopts an objective definition of pre-existing condition in the small group market, which allows insurers to refuse to pay for treatment of a condition only if the patient received medical advice, diagnosis, care, or treatment for the condition prior to coverage.

The ACA also applies to insurers in the small group market and prohibits new plans as well as grandfathered plans (those in existence before the ACA that have not made significant changes since) from imposing pre-existing condition exclusions on children under the age of 19 as of September 2010. In addition, GINA prohibits pre-existing condition exclusions because of genetic information in the absence of a diagnosis of a condition. Federal law also prohibits group plans from treating pregnancy as a pre-existing condition.

How does the ACA affect pre-existing condition exclusions?

Beginning January 1, 2014, the ACA prohibits insurers in the individual and group markets (with the exception of grandfathered individual plans) from imposing pre-existing condition exclusions. The ACA's prohibition on pre-existing condition exclusions will enable consumers to access necessary benefits and services, beginning from their first day of coverage. Beginning in 2014, the ACA will also require insurance companies to guarantee issue health plans to any applicant regardless of his or her health status and impose rating restrictions limiting how much insurers can vary premiums based on an individual's health status.

The ACA also established Pre-existing Condition Insurance Plans (PCIPs) in each state, which opened in July 2010. The PCIPs are federally funded temporary high-risk pools for individuals who have been unable to buy health insurance coverage for at least six months due to a pre-existing condition. Unlike many of the state high-risk pools established before the ACA, the PCIP cannot impose waiting periods for the coverage of pre-existing conditions. Funding for the PCIPs will expire by January 1, 2014, when the ACA's requirement that insurers accept all applicants without imposing pre-existing condition exclusions takes effect.

Current Status and Trends¹

Individual Market

There is significant variation in the ways that states regulate pre-existing condition exclusions. As discussed above, a pre-existing condition is defined differently in different states. Eighteen states use the objective standard definition for pre-existing conditions, under which the insurer can only refuse to pay for treatment of a condition if the patient received an actual diagnosis or treatment for the condition prior to coverage. Twenty-four states allow insurers to use the broader prudent person standard. Eight states and the District of Columbia have not adopted any definition of pre-existing condition.

States also vary in their approach to regulating elimination riders, which are permitted in 36 states and the District of Columbia and prohibited in 14 states. The remaining state, Indiana, prohibits *permanent* exclusion riders, but allows insurers to exclude coverage for certain conditions for up to ten years.

Look-back periods and maximum exclusion periods also vary by state in the individual market. Look-back periods range from three months in one state to unlimited in ten states and the District of Columbia. Maximum exclusion periods also vary: three states impose maximum exclusion periods of six months while nine states and the District of Columbia place no limits on such periods. An additional 36 states impose maximum exclusion periods of 12 months or more.

¹ This discussion is limited to state regulation of pre-existing condition exclusions. For information on state rules related to guarantee issue and rate restrictions, which provide broader protections for people with pre-existing conditions, please see: <http://www.kff.org/healthreform/8328.cfm> and <http://www.kff.org/healthreform/8327.cfm>

Individual Market Pre-existing Condition Exclusion Rules

State	Definition of pre-existing condition	Elimination Riders Permitted	Maximum look-back period (months)	Maximum exclusion period (months)
Alabama	No definition	Yes	60	24
Alaska	No definition	Yes	No limit	No limit
Arizona	No definition	Yes	No limit	No limit
Arkansas	Prudent person standard	Yes	60	No limit
California	Objective standard	No	12	12
Colorado	Objective standard	Yes	12	12
Connecticut	Objective standard	Yes	12	12
Delaware	Prudent person standard	Yes	60	No limit
District of Columbia	No definition	Yes	No limit	No limit
Florida	Prudent person standard	Yes	24	24
Georgia	No definition	Yes	No limit	24
Hawaii	No definition	Yes	No limit	36
Idaho	Prudent person standard	No	6	12
Illinois	Prudent person standard or objective standard	Yes	24	24
Indiana	Prudent person standard	No	12	12
Iowa	Prudent person standard	Yes	60	24
Kansas	No definition	Yes	No limit	24
Kentucky	Objective standard	No	6	12
Louisiana	Prudent person standard	Yes	12	No limit
Maine	Prudent person standard	No	12	12
Maryland	Objective standard	No	12	12
Massachusetts	Objective standard	No	6	6
Michigan	Objective standard	No	6	12
Minnesota	Objective standard	No	6	18
Mississippi	Prudent person standard	Yes	12	12
Missouri	No definition	Yes	No limit	No limit
Montana	Objective standard	Yes	36	12
Nebraska	Prudent person standard	Yes	No limit	No limit
Nevada	Objective standard	Yes	6	No limit
New Hampshire	Objective standard	Yes	3	9
New Jersey	Prudent person standard	No	6	12
New Mexico	Prudent person standard	Yes	6	6
New York	Objective standard	No	6	12
North Carolina	Objective standard	Yes	12	12
North Dakota	Objective standard	Yes	6	12
Ohio	Prudent person standard	Yes	6	12
Oklahoma	Prudent person standard	Yes	60	No limit
Oregon	Objective standard	No	6	6
Pennsylvania	Objective standard	Yes	60	12
Rhode Island	Prudent person standard	Yes	36	12
South Carolina	Prudent person standard	Yes	No limit	24
South Dakota	Prudent person standard	Yes	12	12
Tennessee	No definition	Yes	No limit	24
Texas	Prudent person standard	Yes	60	12
Utah	Objective standard	Yes	6	12
Vermont	Prudent person standard	No	12	12
Virginia	Prudent person standard	Yes	12	9
Washington	Prudent person standard	No	6	12
West Virginia	Prudent person standard	Yes	24	24
Wisconsin	Prudent person standard	Yes	No limit	12
Wyoming	Objective standard	Yes	6	12

Data are as of January 2012 and available at www.statehealthfacts.org

Small Group Market

Two states, Hawaii and Michigan, already ban pre-existing condition exclusions in the small group market while 18 other states have consumer protections for pre-existing conditions that exceed HIPAA's minimum requirements. Two of these 18 states have reduced the maximum look-back period from six months to three months while 11 states have reduced the maximum exclusion period from 12 months to 3, 6, or 9 months. Eleven states allow consumers to have a lapse in coverage of more than 63 days and still credit prior coverage to reduce the pre-existing condition exclusion period. These states either have eliminated maximum lapse periods or set the period at up to 180 days under certain circumstances. An additional 30 states and the District of Columbia meet, but do not exceed, HIPAA's standards on pre-existing condition exclusions in the small group market.



Transition to 2014

Individual Market

Before the ACA, there was no federal standard for most people applying for coverage in the individual market, and state protections for individuals with pre-existing conditions varied. Combined with the ACA's provisions on [guarantee issue](#) and [rating restrictions](#), the ACA's elimination of pre-existing condition exclusions will improve the access, adequacy, and affordability of health insurance for individuals with pre-existing conditions.

By January 1, 2014, states must ensure that plans comply with the ACA's pre-existing condition exclusion standard. The federal government must enforce this rule in states that do not do so. States that currently permit insurers to impose pre-existing condition exclusions will have to amend their

laws or regulations to meet the ACA's standard for pre-existing condition exclusions, as many states have already done to implement the ACA's prohibition on pre-existing condition exclusions for children under 19. In addition, a handful of states have already amended their laws to prohibit pre-existing condition exclusions for adults.

Small Group Market

Although HIPAA already provides some protections for consumers in the small group market, the ACA's elimination of pre-existing condition exclusions ushers in greater protections for employees of small businesses. Because pre-existing condition exclusions in the small group market are still permitted in 48 states and the District of Columbia, these states will need to amend their laws or regulations by January 1, 2014 to comply with the ACA's new prohibition on pre-existing condition exclusions. As in the individual market, the law provides for federal enforcement in states that do not adopt and enforce these protections.

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THE HENRY J. KAISER FAMILY FOUNDATION

www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

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