State Consumer Protections In the Individual Health Insurance Market

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Failing Grades:
State Consumer Protections in the
Individual Health Insurance Market

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INTRODUCTION

As pressure mounts on policymakers to find a solution to America's health care crisis, some lawmakers are promoting the individual health insurance market as the best avenue for reform. They propose providing tax credits for people who seek out and purchase health insurance on their own, suggesting that individuals will be able to find the best deal for themselves. However, without adequate consumer protections, the individual insurance market offers a raw deal. Individuals seeking health coverage on their own have virtually no bargaining power to obtain good health benefits at a reasonable rate.

The task of protecting consumers in the individual market has, for the most part, been left to the states. States have taken some steps to protect consumers, but they face limitations. The insurance lobby is strong, and many insurers would prefer an unregulated market in which they accept only consumers who are good risks for their business. This leaves consumers with a patchwork of protections that are inadequate as a whole and that vary greatly from state to state. In one state, consumers may be able to buy insurance that will cover their medical needs, but only at a very high price. Just across the state line, neighbors with similar medical conditions may find that although policies are cheaper, no insurer will sell to them or insurers will only sell them polices that exclude coverage of the very services that they most need. Consumers are put at the mercy of insurers and the vagaries of states' insurance laws.

In order to understand what Americans face when they purchase health insurance in the individual market, Families USA surveyed all state insurance departments and compiled information on the laws that each state has in place to protect consumers (see the table on page 4). We found that protections vary greatly across the country, and in many states, because of a lack of consumer protections, insurance companies can deny people coverage, raise premiums significantly, refuse to cover treatment for certain conditions, and even revoke the coverage of policyholders who have been paying premiums for years.

KEY FINDINGS

- In the vast majority of states, insurance companies are permitted to reject individuals for coverage based on their health status, occupation, or even their recreational activities.
  - Only five states prohibit all insurance companies from cherry-picking the healthiest consumers and excluding everyone else.
- If an insurance company does accept an individual's application for coverage, few states significantly limit how much an insurer can increase an individual's premiums based on what the insurer deems to be health risks (which can include anything from cold sores to hobbies to below average height).
  - In 35 states and the District of Columbia, there are no limits on how much insurers can vary premiums based on health status. An additional six states have limits that still allow dramatic variations in premiums.
- Insurance companies will not necessarily provide coverage for the very health services individuals need when they sign up for a policy. In all states, insurance companies are not obligated to cover pre-existing conditions for most people for at least the first six months that an individual has a policy.[1]
  - In 21 states and the District of Columbia, insurers can exclude coverage for pre-existing conditions for more than one year.
  - In eight of those states and the District of Columbia, insurers can exclude coverage for pre-existing conditions for the duration of an individual's policy.[2]
- Not every state ensures that premiums are reasonable by reviewing premium rate increases before insurers impose them. And few states require that at least 75 cents of every dollar collected in premiums be spent on medical services rather than administration and profit.
  - In 20 states and the District of Columbia, insurers can set and raise premiums without adequate oversight.
  - In 45 states and the District of Columbia, insurers can spend less than 75 cents of every premium dollar on medical services.
- In the majority of states, insurance companies can move to limit or revoke an individual's policy long after it was purchased by claiming that the policyholder did not adequately reflect his/her medical history on the application. Oftentimes, this leaves individuals with huge medical bills that must be paid out of pocket and no recourse.
  - Insurers in 29 states and the District of Columbia are allowed to look at a policyholder's medical history and perform medical underwriting months, or even years, after they issued the policy.
  - In 44 states and the District of Columbia, insurers can revoke an individual's health insurance policy without advance review by the state.

TABLE KEY

● Full credit ◐ Partial credit ○ No credit

Require insurers to sell coverage to all applicants?	● All insurers in the individual market must offer all policies to all applicants.
Require affordable coverage alternative for uninsurables?	● State has a mechanism (high-risk pool, guaranteed issue plans) that (1) covers all individuals that health plans deny, (2) sets premiums at 125% or less of standard market rates (for some or all products), and (3) offers income-based subsidies. ◐ State has a coverage mechanism that meets two of the three criteria above.
Prohibit higher premiums based on health status?	● State prohibits insurers from varying premiums based on health status or medical history. ◐ State prohibits insurers from varying premiums more than 25% from the index rate based on health status or medical history.
Advance review of proposed premium rates?	● State regulators review rates and premium increases before insurers can charge them. ◐ State regulators review some rates and premium increases before insurers can charge them.
Require insurers to spend at least 75% of premiums on health care?	● State requires all insurers to spend at least 75% of premiums on medical care. ◐ State requires some insurers to spend at least 75% of premiums on medical care.
Limit how long coverage can exclude pre-existing conditions?	● Insurers can exclude coverage of pre-existing conditions only for 0-6 months after enrollment. ◐ Insurers can exclude coverage of pre-existing conditions only for 7-12 months after enrollment. ○ Insurers can exclude coverage of pre-existing conditions for more than 12 months.
Limit look-back period?	● Insurers can look back 0-6 months in an individual's medical history to identify pre-existing conditions. ◐ Insurers can look back 7-12 months in an individual's medical history. ○ Insurers can look back more than 12 months in an individual's medical history.
Use objective standard to define pre-existing conditions?	● State defines pre-existing conditions as conditions a medical professional diagnosed or recommended treatment for. ○ State has no definition for pre-existing conditions or defines them as conditions for which a prudent person would seek treatment.
Require medical underwriting be completed during application?	● Insurers are required to complete all medical underwriting at the time an individual applies for coverage. ◐ Although not required by law, insurers are expected to complete all medical underwriting at the time of application.
Review insurers' requests to revoke coverage?	● State reviews all insurers' requests to revoke individual policies.
Accept appeals when coverage is revoked?	● State gives consumers the right to appeal if their insurer revokes their policy. ◐ State investigates consumer complaints if an insurer revokes a policy.
Review denials for all state-licensed carriers?	● State's external review program is available to consumers in all state-licensed health plans. ◐ External reviews are available to consumers in some health plans (for example, just HMOs).
Make external reviewer decisions binding?	● Insurers must comply with the decisions of the external review agency, unless the insurer litigates.
Offer free external reviews regardless of claim size?	● State offers external reviews without cost and regardless of claim size.

Consumer Protections, by State, as of March 2008

● Full credit ◐ Partial credit ○ No credit

	Availability of Coverage		Premiums		
	Require insurers to sell coverage to all applicants?	Require affordable coverage alternative for uninsurables?	Prohibit higher premiums based on health status?	Advance review of proposed premium rates?	Require insurers to spend at least 75% of premiums on health care?
Alabama	○	○	○	○	○
Alaska	○	○	○	◐	○
Arizona	○	○	○	○	○
Arkansas	○	○	○	●	○
California	○	◐	○	○	○
Colorado	○	◐	○	○	○
Connecticut	○	●	○	●	○
Delaware	○	○	○	○	○
District of Columbia	○	○	○	○	○
Florida	○	○	○	●	○
Georgia	○	○	○	◐	○
Hawaii	○	○	○	◐	○
Idaho	○	◐	○	○	○
Illinois	○	○	○	○	○
Indiana	○	●	○	●	○
Iowa	○	○	○	●	○
Kansas	○	○	○	●	○
Kentucky	○	○	○	○	○
Louisiana	○	○	○	○	○
Maine	●	NA	●	●	○
Maryland	○	●	○	●	○
Massachusetts	●	NA	●	○	○
Michigan	○	○	○	●	○
Minnesota	○	●	◐	●	○
Mississippi	○	○	○	●	○
Missouri	○	◐	○	○	○
Montana	○	●	○	○	○
Nebraska	○	○	○	○	○
Nevada	○	○	○	●	◐
New Hampshire	○	◐	◐	●	○
New Jersey	●	NA	●	○	●
New Mexico	○	◐	○	●	○
New York	●	NA	●	◐	●
North Carolina	○	○	○	●	○
North Dakota	○	○	○	●	○
Ohio	○	○	○	◐	○
Oklahoma	○	○	○	○	○
Oregon	○	●	●	●	○
Pennsylvania	○	○	○	○	○
Rhode Island	○	○	○	●	○
South Carolina	○	○	○	●	○
South Dakota	○	○	○	●	○
Tennessee	○	◐	○	●	○
Texas	○	○	○	○	○
Utah	○	◐	○	○	○
Vermont	●	NA	●	●	◐
Virginia	○	○	○	●	○
Washington	○	●	●	●	●
West Virginia	○	○	○	●	○
Wisconsin	○	◐	○	○	○
Wyoming	○	◐	○	○	○

	Pre-Existing Conditions			Coverage Revocation		
	Limit how long coverage can exclude pre-existing conditions?	Limit look-back period?	Use objective standard to define pre-existing conditions?	Require medical underwriting be completed during application?	Review insurers' requests to revoke coverage?	Accept appeals when coverage is revoked?
Alabama	○	○	●	◐	○	○
Alaska	○	○	○	○	○	○
Arizona	○	○	○	○	○	○
Arkansas	○	○	○	○	○	○
California	◐	◐	●	●	○	●
Colorado	◐	◐	●	●	○	○
Connecticut	◐	◐	●	●	●	●
Delaware	○	○	○	○	○	○
District of Columbia	○	○	○	○	○	●
Florida	○	○	○	●	○	●
Georgia	○	○	○	○	○	○
Hawaii	○	○	○	○	○	○
Idaho	◐	●	○	○	○	●
Illinois	○	○	○	○	○	●
Indiana	◐	◐	○	●	○	●
Iowa	○	○	○	○	○	○
Kansas	○	○	○	○	○	○
Kentucky	◐	●	●	○	○	◐
Louisiana	◐	◐	○	○	○	●
Maine	◐	◐	○	NA	NA	NA
Maryland	○	○	○	●	○	●
Massachusetts	●	●	●	NA	NA	NA
Michigan	◐	◐	●	○	○	◐
Minnesota	○	●	●	○	○	●
Mississippi	◐	◐	○	○	○	○
Missouri	○	○	○	○	○	●
Montana	◐	○	●	○	○	●
Nebraska	○	○	○	◐	○	●
Nevada	○	○	●	○	○	●
New Hampshire	◐	●	●	●	○	○
New Jersey	◐	●	○	NA	NA	NA
New Mexico	●	●	○	●	○	●
New York	◐	●	●	NA	NA	NA
North Carolina	◐	○	●	○	○	○
North Dakota	◐	●	●	○	○	◐
Ohio	◐	●	○	●	○	○
Oklahoma	○	○	○	○	○	◐
Oregon	○	●	●	◐	○	●
Pennsylvania	◐	○	●	●	○	○
Rhode Island	◐	○	○	●	○	●
South Carolina	○	○	○	○	○	◐
South Dakota	◐	◐	○	○	○	◐
Tennessee	○	○	○	○	○	◐
Texas	◐	○	○	○	○	◐
Utah	◐	●	●	○	○	○
Vermont	◐	●	○	NA	NA	NA
Virginia	◐	◐	○	●	○	○
Washington	◐	●	○	●	○	●
West Virginia	◐	○	○	○	○	○
Wisconsin	○	○	○	○	○	●
Wyoming	◐	●	●	○	○	○

Consumer Protections, by State, as of March 2008 (continued)

	Enforcement of Rights		
	Review denials for all state-licensed carriers?	Make external reviewer decisions binding?	Offer free external reviews regardless of claim size?
Alabama	◐	Unknown	Unknown
Alaska	●	●	●
Arizona	●	●	●
Arkansas	●	●	○
California	●	●	●
Colorado	●	●	●
Connecticut	●	●	○
Delaware	●	●	●
District of Columbia	●	○	●
Florida	◐	●	●
Georgia	◐	●	○
Hawaii	◐	●	○
Idaho	○	○	○
Illinois	◐	●	●
Indiana	◐	●	●
Iowa	●	●	○
Kansas	●	●	●
Kentucky	◐	●	○
Louisiana	●	●	●
Maine	●	●	●
Maryland	●	●	●
Massachusetts	●	●	○
Michigan	●	●	●
Minnesota	●	●	○
Mississippi	○	○	○
Missouri	●	●	○
Montana	●	●	●
Nebraska	○	○	○
Nevada	◐	●	○
New Hampshire	●	●	○
New Jersey	●	●	○
New Mexico	◐	●	●
New York	●	●	○
North Carolina	●	●	●
North Dakota	○	○	○
Ohio	●	●	○
Oklahoma	●	○	○
Oregon	●	○	●
Pennsylvania	◐	●	○
Rhode Island	◐	●	○
South Carolina	●	●	○
South Dakota	○	○	○
Tennessee	◐	●	○
Texas	●	●	●
Utah	●	●	●
Vermont	●	●	○
Virginia	◐	●	○
Washington	●	●	●
West Virginia	◐	●	○
Wisconsin	●	●	○
Wyoming	○	○	○

For more state-specific information on consumer protections, see Table Notes on page 29.

DISCUSSION

Consumer protections in the individual health insurance market vary greatly by state. In order to better understand what consumers face, we have divided these protections into the following areas:

- Availability of coverage,
- Premiums,
- Pre-existing conditions,
- Coverage revocation, and
- Enforcement of rights.

Availability of Coverage

Question: Are insurers required to sell coverage to all?

While employers are guaranteed the right to purchase health insurance, the vast majority of states do not guarantee most individuals the right to purchase coverage.[3] Insurers can refuse to sell individuals policies based on their health, recreational activities, occupations, credit histories, and a variety of other factors.[4]

Data kept in one state show that about 14 percent of people who seek individual coverage are deemed "uninsurable" and, based on their health status, are denied coverage by *all* private insurers. Some insurers deny close to 40 percent of applicants based on their health, their jobs, hobbies that put them at risk of injury, or other "risk factors."[5] People may be denied coverage merely because they take common drugs like Celebrex (for arthritis pain), Lipitor (for high cholesterol), and Nexium (for heartburn and acid reflux), even if they are taking these drugs to prevent a problem and have not actually had a serious health episode.[6]

Only five states have **guaranteed issue** laws that require insurance companies to accept all individuals who apply for coverage regardless of their health or other factors. Guaranteed issue provides the simplest access to health coverage for consumers, allowing them to seek out the most appropriate plan for their needs.

Many more states have had varying degrees of success with establishing alternative methods of providing coverage to individuals that insurance companies reject. Some states have formed **high-risk pools**—nonprofit associations that provide coverage for people who have been turned down by individual market insurers because of high-risk health conditions. Other states designate particular insurers, such as nonprofit health

plans or HMOs, that must issue policies to all applicants. Applicants may be enrolled in these guaranteed issue plans continuously or during a specified open enrollment period.

Evidence shows that a very small percentage of eligible individuals enrolls in the alternative high-risk pool or guaranteed issue plan.[7] High-risk pools and guaranteed issue plans are helpful to some, but requiring insurers to sell coverage to all applicants would be more beneficial for most consumers.

Consumer Voices: Availability

Georgia is one state that does not guarantee access to coverage for people in poor health. People with seemingly minor conditions, as well as those with serious illnesses, have found themselves unable to buy health insurance at any price.

Theresa lives with her family in Georgia and is looking to purchase health insurance for her son Logan. Theresa has been able to find coverage for the rest of her family, but she can't find an insurance company that will cover her son, not because he has a serious health problem, but because he is ranked in a lower-than-average height percentile for his age. Theresa cannot find him coverage at any price, and she cannot understand why Logan should be uninsurable simply because he is short.

Findings

- **Requiring Insurers to Sell Coverage to All Applicants**
    - Only five states guarantee that all insurers will sell all policies to individuals regardless of their health.[8]
- **Requiring an Affordable Coverage Alternative for Uninsurables**
    - Five states guarantee by law that at least one designated insurer will offer coverage to all individuals, or that certain policies are available to all individuals, regardless of health.[9]
        - North Carolina and the District of Columbia each have an insurance company that has agreed to accept all applicants, but there are no laws guaranteeing consumers the right to buy policies.
        - In four states and the District of Columbia, there are no limits on how much premiums will cost for the guaranteed issue plan.[10]
    - Thirty-one states guarantee that all individuals can be sold policies through a high-risk pool.[11] However, most of the high-risk pools are unaffordable for the majority of individuals seeking coverage.

    - Only three states have laws requiring that premiums for high-risk pools stay at reasonable levels (within 25 percent of the premiums charged to other people in the private market). An additional eight states report that the premiums for some high-risk pool plans are within 25 percent of the market standard.[12]
    - Only 13 states provide additional assistance to help low-income individuals pay high-risk pool premiums.[13]
  - Seven states do not guarantee that any insurer will sell policies to all individuals and do not have any voluntary arrangements with insurers to accept all applicants.[14]

Premiums

Question: Are insurers prohibited from charging higher premiums based on health status?

The majority of uninsured Americans report that the main reason they do not have health coverage is because it is unaffordable. In most states, there are no limits on how much an insurance company can vary premiums based on an individual's health status. Common health issues such as acid reflux and back pain can add hundreds of dollars to an individual's monthly premium, oftentimes leaving people with no affordable coverage options.

Some states protect consumers by prohibiting insurance companies from looking at individuals' health to determine premiums. Other states put limits on how much higher insurers can set premiums based on health status. These limits, called **rate bands**, establish a maximum percentage that an insurer can increase an applicant's premium from the average ("index") rate[15] based on that applicant's health. However, it is worth noting that rate bands are most beneficial to consumers when paired with a guaranteed issue policy that prohibits insurers from denying coverage based on health status.

Findings

- **Prohibiting Higher Premiums Based on Health Status**
  - Five states require insurers to accept all applicants and prohibit higher premiums based on health status. Two states do not require insurers to accept all applicants, but they do prohibit higher premiums based on health status.[16]
  - Two states have rate bands of 25 percent or less that limit premium variation based on health in the individual market.[17]
  - Thirty-five states and the District of Columbia have no limits on premium variation based on health status. An additional six states have limits that still allow dramatic variations in premiums.[18]

Question: Are consumers protected from excessive premiums?

In many states, insurance companies can set premiums at exorbitantly high rates without any state agency intervening on behalf of individual policyholders. However, states do have jurisdiction to oversee insurance companies' premium increases by requiring insurers to submit proposed rates and proposed rate increases for **prior approval**. Under prior approval, insurance companies must file documents with the state to justify their proposed premiums for new and existing products. Insurers cannot actually begin charging the proposed rates until the state department of insurance has had a given number of days to review the rates and approve or deny them.

States report that they receive outlandish proposals from insurance companies to increase rates by as much as 100 percent, and states that have prior approval authority can deny those proposals. In addition, insurers increase premiums for policyholders too frequently, and prior approval puts an outside review process in place to examine the rates and stop excessive charges.

Consumer Voices: Excessive Premium Increases

Karen lives in Seattle, Washington and suffers from rheumatoid arthritis, a condition that requires her to have a medication infusion every seven weeks. Without insurance, a single infusion would cost her $7,000. Karen has an individual health insurance policy with Regence BlueShield, and in 2007, Regence significantly raised premiums for people with individual policies. The company levied the largest rate increases on older individuals, and Karen's premium jumped by 42 percent. Karen's health insurance premium is quickly becoming as expensive as her house payment, and she worries that one day she will no longer be able to afford health coverage. In 2008, Washington passed a new law giving the insurance department authority to reject unreasonable rate increases like the one Karen experienced.[19]

Findings

- **Advance Review of Proposed Premium Rates**
  - Twenty-five states give the insurance department authority to approve premium rates for all individual health insurance plans prior to the rates going into effect.[20]
  - Five states give prior approval of premium rates for only some individual health insurance policies.[21]
  - Twenty states and the District of Columbia do not approve premium rates before they go into effect.[22]

Question: Are insurers required to put premiums toward medical care rather than profits?

In the majority of states, there are no protections in place that ensure consumers who are buying coverage in the individual market that their premiums will be used for medical services rather than for insurance company profit, administration, and advertising. In fact, without adequate consumer protections, insurance companies sometimes spend only 60 cents of every premium dollar on actual health care.[23]

A handful of states require insurance companies to spend at least 75 cents of every premium dollar on medical care, retaining 25 cents or less for administration, marketing, and profit. In these states, if an insurer does not spend enough premium dollars on medical care, it must either refund consumers or adjust its premiums accordingly for the following year. This requirement is called a **minimum medical loss ratio**. Without a minimum medical loss ratio, insurance companies can charge very high premiums to individuals and spend a startlingly low proportion of these premium dollars on health care services. This requirement holds insurance companies accountable. For example, as a result of New Jersey's minimum medical loss ratio, consumers have received refunds of premium dollars not spent on medical care.

Insurance companies should be required to spend a reasonable portion of premiums on medical care, and they should not be making high profit margins on the backs of consumers. Currently, several states (such as California, Illinois, and Pennsylvania) are proposing an 85 percent minimum medical loss ratio. Limiting private insurers' administrative overhead and profit is an important measure that can ensure that consumers are receiving the health services for which they are paying top dollar.

Findings

- **Requiring Insurers to Spend at Least 75 Percent of Premiums on Health Care**
  - Three states require all insurers in the individual market to spend at least 75 cents of every premium dollar on medical care.[24]
  - Two states require some insurers to spend at least 75 cents of every premium dollar on medical care for certain policies.[25]
  - Forty-five states and the District of Columbia do not require insurers to spend at least 75 cents of every premium dollar on medical care.[26]

Pre-Existing Conditions

Question: Is there a limit on how long insurers can exclude coverage for pre-existing conditions?

Even when people are able to find affordable coverage in the individual market, they are likely to find that this coverage does not meet their immediate health needs. Insurance companies generally can exclude coverage for the treatment of **pre-existing conditions**, which are health problems that individuals already had when they purchased coverage.[27] For example, if you had a heart condition before you bought your current insurance plan, that plan might not cover heart attacks that occur within a specified number of months after you enroll, or the plan might not cover future heart attacks at all.

In order to protect consumers, some states limit the length of time that insurers can exclude coverage of pre-existing conditions to six months from the time an individual purchased his or her policy. Other states prohibit pre-existing condition exclusion periods that are longer than one year.[28] Only 12 states prohibit insurers from selling policies that contain **elimination riders**—contractual clauses that say that the insurer will never cover an individual's treatment for a specific condition.[29]

Another important consumer protection that some states use is placing a limit on the **look-back period**, which is how far back into an individual's medical history insurance companies can look to decide what health conditions they will not cover. For example, an insurance company would not be allowed to deny services related to back pain because a consumer received physical therapy for back pain years ago due to an unrelated sports injury.

In order to protect consumers, some states use the **objective standard** that defines a pre-existing condition as a health condition for which a health care professional provided or recommended treatment, as opposed to a condition that an individual unknowingly had and that had not been diagnosed by a health care provider.

Consumer Voices: Pre-Existing Conditions

Teresa, a small businesswoman in North Carolina, tried to buy coverage as an individual last year. She did not anticipate the ramifications of a few relatively common health issues she had experienced: Teresa had undergone physical therapy five years before for back pain, and she occasionally suffered from acid reflux and cold sores. Unfortunately, one insurance company placed a three-year exclusion period on any treatment related to all three conditions. Another insurance company offered Teresa coverage for $727 a month that would exclude any treatment for her back. Teresa's husband Jim wonders what would have happened if she had more serious health conditions and needed insurance.

Findings

- **Limiting How Long Coverage Can Exclude Pre-Existing Conditions**
  - Two states limit the pre-existing conditions exclusion period to six months or less.[30]
  - Twenty-seven states limit the pre-existing conditions exclusion period to nine or 12 months.[31]
  - Twenty-one states and the District of Columbia allow insurers to exclude coverage of a pre-existing condition for more than one year.[32]
- **Limiting the Look-Back Period**
  - Fifteen states limit to six months or less how far insurers can look back into an individual's medical history to define coverage exclusions.[33]
  - Ten states limit to 7-12 months how far insurers can look back into an individual's medical history to define coverage exclusions.[34]
  - Twenty-five states and the District of Columbia do not limit to one year how far insurers can look back into an individual's medical history to define coverage exclusions.[35]
- **Using the Objective Standard to Define Pre-Existing Conditions**
  - Eighteen states use the objective standard to define pre-existing conditions.[36]
  - Thirty-two states and the District of Columbia use no standard or the "prudent person" standard, which defines a pre-existing condition as a condition for which a prudent person would have sought medical attention.[37]

Coverage Revocation

Question: Are consumers protected from having their coverage taken away?

Among the most appalling insurance company practices is that of revoking an individual's health insurance policy or suddenly eliminating coverage for crucial health services long after enrollment. In some cases, people have paid insurance premiums for months or even years before they required medical services that led their insurance company to reexamine their medical histories and dramatically change or completely revoke their policies. In almost every state, individuals are at risk of seeing their health coverage evaporate before their eyes, leaving them with unfathomable medical bills. Federal law prohibits insurance companies from dropping coverage based on a person's health status. However, insurers can drop coverage if a person is said to have "misrepresented" his or her condition on an application. And insurers in most states can add vague clauses to contracts that exclude coverage for unnamed pre-existing conditions. These loopholes are often abused by insurers.

In almost every state, when people apply to purchase individual health insurance, insurers can ask applicants questions about their medical histories. Insurance companies use this process of **medical underwriting** to determine whether or not to offer a policy, what the

premium will be, whether to permanently exclude coverage for a designated condition, and whether to refuse to cover a particular pre-existing condition for a set period of time.

When it comes to medical underwriting, insurance companies are the experts. Consumers expect that when they receive insurance coverage, the insurer has completed the medical underwriting process, and they will be covered according to the terms of their insurance contracts. Unfortunately, most states allow (tacitly—if not explicitly) insurance companies to perform medical underwriting, or to conduct more stringent underwriting, long after a policy has been issued to a consumer. This is called **post-claims underwriting**. When individuals need costly medical treatment long after purchasing their policies, insurance companies dig further into their medical histories and retroactively limit or revoke coverage. In these cases, insurers claim that individuals should have known about their health condition before they bought policies. Consumers are then shocked to find themselves without coverage.

Important statutory protections, oversight, and stringent enforcement are necessary to shield consumers from predatory post-claims underwriting. Government has a role as a watchdog in this arena, and it can protect consumers by adopting the following provisions:

- Require insurers to define pre-existing conditions that consumers must disclose on their application as treatment that has been received or recommended by a medical professional within the last two years. Using this kind of objective standard prevents insurers from alleging that policyholders should have known they had a medical condition, even though no medical professional told them as much.
- Prohibit insurers from investigating more than six months of an individual's medical history to find pre-existing conditions. In some states, insurers can look back many years to identify conditions that they will not cover, even if the person has been healthy in the interim.
- Require insurers to present clear questions on insurance applications and to communicate the importance of answering completely.
- Require insurers to complete all medical underwriting at the time of application and contact applicants or review additional health information to clarify any confusing or incomplete answers before issuing a policy.
- Prohibit insurers from limiting or revoking policies, or at least prohibit limitations and revocations after policyholders have had their policies for a period of time.
- Prohibit insurers from refusing to pay providers for treatment that they have already authorized after policies are cancelled.

- Require that insurers submit requests to revoke policyholders' coverage to the state insurance commissioner for review.
- Give consumers the opportunity to participate in any investigations about whether they willfully misrepresented their health on applications, and allow consumers to appeal decisions both through their health plan and through an outside government agency.
- Have state insurance regulators oversee insurance companies to ensure that those companies are complying with the state's consumer protections.

Consumer Voices: Coverage Revocation

Maria from Connecticut had insurance (a Fortis plan from Assurant) when she went to the doctor with what she thought was a pinched nerve and was diagnosed with non-Hodgkin's lymphoma. Assurant denied payment for the cancer-related bills, saying that she had this condition before she bought her policy, and she should have sought treatment. "If I thought I had cancer the previous month, why wouldn't I have gone to the doctor then? They expected me to be clairvoyant," Maria said.[38]

Findings

- **Requiring Medical Underwriting Be Completed during Application**
  - Thirteen states report that they require insurers to complete all medical underwriting and resolve all questions at the time of application.[39]
  - Three additional states report that they do not have laws that require insurers to complete all medical underwriting at the time of application, but they nonetheless enforce this policy.[40]
  - Twenty-nine states and the District of Columbia do not require insurers to complete all medical underwriting and resolve all questions at the time of application.[41]
- **Reviewing Insurers' Requests to Revoke Coverage**
  - Only one state requires insurers to obtain the state's permission in advance to limit or revoke a policyholder's coverage due to his or her medical history.[42]
  - Forty-four states and the District of Columbia allow insurers to limit or revoke coverage of individual policyholders without the state's review.[43]
- **Accepting Appeals When Coverage Is Revoked**
  - Eighteen states and the District of Columbia report that they give consumers appeal rights if their policy is revoked.[44]
  - An additional eight states have no formal appeals process, but they investigate consumer complaints if coverage is revoked.
  - In 19 states, consumers do not have appeal rights if their policy is revoked.[45]

Enforcement of Rights

Question: Are consumers protected if their insurance companies refuse to pay for services?

Nowadays, virtually all insurance companies review all the services and prescription drugs that health care providers recommend and administer to their patients, a process known as **utilization management**. Insurers say they monitor to ensure that policyholders are receiving treatment that is medically necessary and effective. However, an insurer's bottom line is better when medical claims are fewer and cheaper, which provides a financial incentive to deny services that may greatly benefit the health of the policyholder.

Many states have established programs in which an objective third party evaluates disputes between insurance companies and policyholders over service denials, called **external review**. These programs provide a crucial consumer protection that allows individual market policyholders to contest decisions by their insurance company.

Utilization management was pioneered by HMOs and other managed care health plans to keep premiums low. In the 1990s, before external review was available, the media exposed outrageous abuses that clearly demonstrated the need for a review system outside of health plans.[46] Now that utilization management is widely practiced, it's important that the law make external review available to policyholders with any type of health plan, not just HMOs. On average, external reviewers decide in favor of consumers and overturn health plans' decisions in 40 percent of cases, and in some states, the rate is much higher (for example, 71 percent of health care plans' decisions are overturned in Vermont).[47]

Some states require that the external review process be available to policyholders in all state-licensed health plans. Other states make external review available only to policyholders with HMOs or managed care plans, and this cuts off potential consumer challenges to other kinds of plans.

In the vast majority of states, insurance companies are required to abide by the decision made by the external reviewer (unless the insurer takes the case to court and wins). Only the District of Columbia, Oklahoma, and Oregon do not require insurers to comply with the external reviewer's decision.

In order to make the review process available to the policyholders that need it, external reviews should be available to consumers without fees and regardless of the amount of the claim being disputed. A few states require consumers to pay a fee to obtain external review. Other states do not provide external review if contested claims are below a specific minimum dollar amount, such as $100. Both of these prerequisites create a significant barrier to a process that is already underutilized.

Only a small number of consumers use external reviews. This could indicate that the system is working: consumers agree with insurers' decisions, or they are resolving disputes with the insurers without the need for external reviews. Or, a small number of external reviews could indicate weaknesses in consumer protections, such as the following: consumers never find out about the formal appeals process, they give up on their cases during negotiations before they get to an appeal, or they cannot successfully appeal because their state does not have any rules to protect them against consumer abuses (such as excessive premiums, pre-existing condition exclusions, and policy revocations). While external review is an essential protection for people denied crucial medical services, it is important to remember that states must do much more to protect consumers.

Consumer Voices: Enforcement of Rights

A six-year-old Michigan girl with cerebral palsy underwent an operation on her left hip in 2006. Following surgery, she was in a full body cast for eight weeks. The girl required physical and speech therapy for about seven months to recover from the surgery and period of immobility. Together, the physical and speech therapy claims totaled $10,340. The family's health insurance plan denied the claims, arguing that the therapy was for maintenance rather than recovery, and left the family to pay the bill. The girl's father exhausted the health insurance plan's internal review process, and the case went before Michigan's independent review organization. In February 2008, the independent review organization overturned the insurance company's decision, and the company was required to cover the girl's services.[48]

Findings

- **Reviewing Denials for All State-Licensed Carriers**
  - Thirty states and the District of Columbia have external review for all state-licensed health plans.[49]
  - Fourteen states provide external review only for managed care organizations, such as HMOs, and six states do not provide external review at all.[50]
- **Making External Reviewer Decisions Binding**
  - In two states and the District of Columbia, insurers are not bound by the external reviewer's decision.[51]
- **Offering Free External Reviews Regardless of Claim Size**
  - In 20 states and the District of Columbia, consumers can obtain external review without paying any fees, regardless of the dollar value of the disputed claims.[52]

CONCLUSION

Some states have put laws into place that protect consumers in the individual health insurance market, but other states are lagging far behind. The result is a patchwork of protections that, on the whole, leaves consumers to fend for themselves. Without adequate protections, insurers can deny coverage, charge exorbitant premiums, and even revoke people's policies without warning. If individuals are expected to seek out health coverage on their own, a cohesive system of adequate consumer protections should be in place to ensure their access to quality, affordable coverage.

ENDNOTES

[1] Only people who previously had continuous coverage through job-based plans are protected from pre-existing condition exclusions under federal law.

[2] Kaiser State Health Facts Online, *Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals), 2007*, available online at http://www.statehealthfacts.org/comparetable.jsp?ind=355&cat=7, accessed on May 19, 2008. AK, AZ, AR, DE, DC, MO, NE, NV, and OK.

[3] Federal law protects guaranteed access to insurance for people buying individual coverage only when they first leave their jobs. Individuals are guaranteed the right to purchase coverage under federal law if they meet all of the following conditions: they had at least 18 months of insurance coverage without a gap of 63 days or more; they used up COBRA options or similar state options for continuation coverage; they were most recently enrolled in an employer-sponsored group plan; and they are not eligible for Medicaid, Medicare, or coverage through another employer-sponsored plan.

[4] The Texas Office of Public Insurance Counsel publishes a summary of underwriting guidelines used by insurance carriers in that state: *2007 Individual Health Underwriting Guidelines* (Austin: Office of Public Insurance Counsel), available online at http://www.opic.state.tx.us/docs/442_2007_health_ug.pdf.

[5] Maryland Insurance Administration, *Individual Health Benefit Plan Application and Declinations, YTD March 31, 2007* (Baltimore: Maryland Insurance Administration, 2007). In Washington, insurers denied 15-20 percent of cases prior to 1994 when the state enacted other reforms, first requiring guaranteed issue by all carriers, and later requiring that carriers guarantee issue to all but the riskiest 8 percent of cases. These cases were instead insured by a high-risk pool. Elizabeth Lief and John Gabriel, *Washington State Health Insurance Pool: A Study of Eligibility Standards for Pool Coverage* (Denver: Lief Associates, Inc, December 2007), available online at https://www.wship.org/Docs/WSHIP%20Eligibility%20Study%20120107.pdf.

[6] Lisa Girion, "Health Insurers Deny Policies in Some Jobs; Common Medications Can Also Be Deemed Too Risky in California," *Los Angeles Times*, January 8, 2007.

[7] According to the Washington State Health Insurance Pool (WSHIP) *2007 Annual Report*, only about 16 percent of individuals who were denied coverage on the individual market enrolled in the high-risk pool.

[8] ME, MA, NJ, NY, and VT.

[9] MI, OH, PA, RI, and VA.

[10] DC, MI, PA, RI, and VA.

[11] AK, AR, CA, CO, CT, ID (all carriers issue a standard product), IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, ND, OK, OR, SC, TN, TX, UT, WA, WV, WI, and WY.

[12] CA, MN, and OR have regulations. Eight additional states reported having at least one product priced within this range, even in the absence of law or regulation: CT, ID, IN, MD, MO, MT, NH, and WA.

[13] CO, CT, IN, MD, MN, MT, NM, OR, TN, UT, WA, WI, and WY. However, subsidy programs may be more meaningful in some states than in others. We did not attempt to evaluate the differences in subsidy programs.

[14] AL, AZ, DE, FL, GA, HI, and NV.

[15] The rate band is the average between the highest and lowest possible rate for an individual policyholder, not the average across consumers.

[16] ME, MA, NJ, NY, and VT prohibit insurers from varying premiums based on health status and require insurers to accept all applicants. OR and WA prohibit insurers from varying premiums based on health status, but do not require insurers to accept all applicants.

[17] MN and NH.

[18] Thirty-five states and the District of Columbia do not limit how high insurers can set premiums for individuals based on health status: AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KS, MD, MI, MS, MO, MT, NE, NM, NC, ND, OH, OK, PA, RI, SC, TN, TX, VA, WV, WI, WY. Six states have limits that still allow dramatic variations in premiums based on health status: ID, KY, LA, NV, SD, and UT.

[19] Julie Chinitz and Sam Blair, *Insuring Health or Ensuring Profit? A Look at the Financial Gains of Washington State's Health Insurers* (Seattle: Northwest Federation of Community Organizations, 2008).

[20] AR, CT, FL, IN, IA, KS, ME, MD, MI, MN, MS, NV, NH, NM, NC, ND, OR, RI, SC, SD, TN, VT, VA, WA, and WV.

[21] AK, GA, HI, NY, and OH.

[22] AL, AZ, CA, CO, DE, DC, ID, IL, KY, LA, MA, MO, MT, NE, NJ, OK, PA, TX, UT, WI, and WY.

[23] Health insurance regulators in states with prior approval report that medical loss ratios in the individual market are typically low, around 60 percent, unless the state requires a minimum loss ratio. Based on Families USA interviews with health insurance regulators in 19 states in December 2007 and January 2008.

[24] NJ, NY, and WA.

[25] NV and VT.

[26] AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WV, WI, and WY.

[27] Federal law provides some protections for consumers who leave job-based coverage, exhaust their COBRA benefits, and then buy individual coverage through certain insurers without a lapse of more than 63 days.

[28] States that have such limitations also typically reduce allowable exclusions for people who are simply changing health insurers and who have had coverage for their condition in the immediate past, rather than purchasing coverage after a period without insurance.

[29] Research by Health Policy Institute, Georgetown University, compiled in *Individual Market Portability Rules, 2007* (Washington: Kaiser Family Foundation, 2007) on Statehealthfacts.org.

[30] MA and NM.

[31] CA, CO, CT, ID, IN, KY, LA, ME, MI, MS, MT, NH, NJ, NY, NC, ND, OH, PA, RI, SD, TX, UT, VT, VA, WA, WV, and WY.

[32] AL, AK, AZ, AR, DE, DC, FL, GA, HI, IL, IA, KS, MD, MN, MO, NE, NV, OK, OR, SC, TN, and WI.

[33] ID, KY, MA, MN, NH, NJ, NM, NY, ND, OH, OR, UT, VT, WA, and WY.

[34] CA, CO, CT, IN, LA, ME, MI, MS, SD, and VA.

[35] AL, AK, AZ, AR, DE, DC, FL, GA, HI, IL, IA, KS, MD, MO, MT, NE, NV, NC, OK, PA, RI, SC, TN, TX, WV, and WI.

[36] AL, CA, CO, CT, KY, MA, MI, MN, MT, NV, NH, NY, NC, ND, OR, PA, UT, and WY.

[37] AK, AZ, AR, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, LA, ME, MD, MS, MO, NE, NJ, NM, OH, OK, RI, SC, SD, TN, TX, VT, VA, WA, WV, and WI.

[38] Diane Levick, "State Probing Health Insurer: Assurant Health Facing Allegations That It Unfairly Denied Claims," *Hartford Courant*, January 18, 2007.

[39] CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, VA, and WA.

[40] AL, NE, and OR.

[41] AK, AZ, AR, DE, DC, GA, HI, ID, IL, IA, KS, KY, LA, MI, MN, MS, MO, MT, NV, NC, ND, OK, SC, SD, TN, TX, UT, WV, WI, and WY.

[42] CT.

[43] AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WV, WI, and WY.

[44] CA, CT, DC, FL, ID, IL, IN, LA, MD, MN, MO, MT, NE, NV, NM, OR, RI, WA, and WI.

[45] Eight states report that they have no formal appeals process, but investigate consumer complaints if coverage is revoked: KY, MI, ND, OK, SC, SD, TN, and TX. Nineteen states report that consumers do not have appeal rights if their policy is limited or revoked: AL, AK, AZ, AR, CO, DE, GA, HI, IA, KS, MS, NH, NC, OH, PA, UT, VA, WV, and WY.

[46] Geraldine Dallek, *HMO Consumers at Risk* (Washington: Families USA, July 1996).

[47] America's Health Insurance Plans (AHIP), *Update on State External Review Programs* (Washington: AHIP, January 2006), available online at http://www.ahipresearch.org/pdfs/External_ReviewJan06.pdf.

[48] Ken Ross, Commissioner of State of the Office of Financial and Insurance Services, Michigan Department of Labor & Economic Growth, *Petitioner v. Blue Cross and Blue Shield of Michigan Respondent, File Number 87071-001* (February 26, 2008), available online at http://www.michigan.gov/documents/dleg/02-26-08_87071_BCBSM_230281_7.pdf. Patient's Right to Independent Review Act (PRIRA) case records are available online at http://www.michigan.gov/dleg/0,1607,7-154-10555_20594_20596---,00.html.

[49] AK, AZ, AR, CA, CO, CT, DE, DC, IA, KS, LA, ME, MD, MA, MI, MN, MO, MT, NH, NJ, NY, NC, OH, OK, OR, SC, TX, UT, VT, WA, and WI.

[50] Fourteen states provide external review only for some health plans, such as HMOs: AL, FL, GA, HI, IL, IN, KY, NV, NM, PA, RI, TN, VA, and WV. Six states offer no external review process at all: ID, MS, NE, ND, SD, and WY.

[51] DC, OK, and OR.

[52] AK, AZ, CA, CO, DE, DC, FL, IL, IN, KS, LA, ME, MD, MI, MT, NM, NC, OR, TX, UT, and WA.

APPENDIX:

Methodology
Reader's Notes
Table Notes

METHODOLOGY

Families USA surveyed all state departments of insurance and high-risk pools administrators between March and April 2008 to compile information for this report. We developed a questionnaire and used the following secondary sources to gather preliminary information:

- Kaiser State Health Facts Online, *Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals), 2007*, http://www.statehealthfacts.org/comparetable.jsp?ind=353&cat=7.
- Kaiser State Health Facts Online, *Individual Market Rate Restrictions, 2007*, http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7.
- Kaiser State Health Facts Online, *Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals), 2007*, http://www.statehealthfacts.org/comparetable.jsp?ind=355&cat=7.
- Kaiser State Health Facts Online, *Patients' Rights: External Review, 2006*, http://www.statehealthfacts.org/comparetable.jsp?ind=361&cat=7.
- National Association of Insurance Commissioners, *Compendium of State Laws on Insurance Topics: Filing Requirements, Health Insurance Forms and Rates* (Kansas City: National Association of Insurance Commissioners, November 2005).
- Karen Pollitz, Jeff Crowley, Kevin Lucia, Eliza Bangit, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation* (Washington: Kaiser Family Foundation, May 2002), available online at http://www.kff.org/insurance/externalreviewpart2rev.pdf.
- National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, Twenty-First Edition, 2007/2008* (Denver: National Association of State Comprehensive Health Insurance Plans, 2007).

We mailed questionnaires containing our preliminary results, as well as several open-ended questions, to all state insurance departments asking them for updates and missing information.

When clarification was needed, we turned to state laws and regulations and re-contacted health insurance analysts and actuaries in state insurance departments. All states responded.

READER'S NOTES

Requiring Insurers to Sell Coverage to All Applicants

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires all states to designate at least one health plan that will sell policies to people who meet all five of the following requirements ("HIPAA-eligibles"):

- They had at least 18 months of insurance coverage without a gap of 63 days or more;
- They most recently were covered through an employer-sponsored group plan;
- They used up their COBRA coverage or any state options for continuation coverage;
- They are not currently eligible for Medicaid, Medicare, or coverage through an employer-sponsored plan; and
- They did not lose coverage by failing to pay premiums or for fraud.

There are no federal limits on premium prices for HIPAA-eligibles, and in some states, premiums for HIPAA-eligibles are much more expensive than for average consumers. States often use high-risk pools to serve HIPAA-eligibles, and in a few states, these high-risk pools do not sell policies to anyone else.

The following groups are not guaranteed coverage by any federal laws:

- People changing from one individual insurance plan to another,
- People who were uninsured for 63 days or more and who are now trying to buy individual coverage,
- People who are leaving job-based coverage but who were insured for fewer than 18 months,
- People who have not exhausted COBRA benefits, and
- People who had Medicaid or other public coverage but have lost eligibility.

In the five states that guarantee issuance of all health insurance plans, the price of those policies does not increase based on health status. However, these states have faced other challenges in keeping premiums affordable. For example, in some of these states, comprehensive policies compete for members with inexpensive policies that provide fewer benefits. Because more unhealthy people enroll in the comprehensive policies, premium prices for the most comprehensive plans have risen steeply. These states are trying different approaches to spread the cost of health care over a larger pool of people and thus lower premiums. New York uses reinsurance (discussed in Families USA, *Reinsurance: A Primer*, April 2008, available online at http://www.familiesusa.org/assets/pdfs/reinsurance-a-primer.pdf), and Massachusetts has enacted several other major reforms to keep individual insurance premiums affordable (described in Families USA, *Massachusetts Health Reform of 2006,* August 2007, available online at http://www.familiesusa.org/assets/pdfs/state-expansions-ma.pdf). Additionally, the guaranteed issue states provide a variety of subsidized insurance

programs to help low-income consumers afford health insurance. For this scorecard, we did not collect information on subsidy programs in states that guarantee issuance.

Requiring an Affordable Coverage Alternative for Uninsurables

Among states that use high-risk pools, all states provide some subsidies to keep premiums for people with high medical costs within a certain percentage of standard market premiums. Otherwise, premiums in these pools would be much higher. Beyond this overall subsidy for all high-risk pool enrollees, some states provide an additional subsidy to high-risk pool participants with low incomes. We gave all states full credit if they provide both an overall subsidy that keeps risk pool premiums within 125 percent of standard market premiums and an additional subsidy for low-income people. However, readers should be aware that some high-risk pools provide more assistance to low-income people than others, and there is room to improve the subsidy programs in all states. We did not attempt to compare and score the subsidy programs within the high-risk pools.

Prohibiting Higher Premiums Based on Health Status

States that use rate bands typically set an index rate, which is the arithmetic average of the lowest rate charged for a product and the highest amount charged for a product. States then say that rates can vary up or down from that index rate by a given amount (for example, 25 percent). This means that premiums for people in poor health are actually 1.67 times more than they are for people in good health (because the highest possible premium, 1.25 of the index rate, divided by the lowest possible premium, 0.75 of the index rate, equals 1.67.) We gave half credit to states that allowed insurers to vary rates based on health by no more than this amount. We picked this number because when we looked at data on high-risk pools, states that limit high-risk pool premiums to 125 percent or less of average premium rates seem to have significantly more enrollees than states that allow higher premiums. Others might argue that a different amount is a more reasonable maximum.

Prohibiting higher premiums based on health status works together with guaranteed issue. If an insurer can only charge consumers 25 percent higher premiums based on health status, but it can deny people coverage altogether based on a health condition, the rating protection does not help much. To get a full picture of the prices that insurers are charging, you will want to know how they set the prices that they charge to average consumers to reasonably reflect costs; to what extent they accept less healthy consumers and what they charge them; and, if particular plans cannot turn people down, how much more those plans are allowed to charge consumers. Two states, Utah and Washington, require all health plans to follow the same medical criteria to determine who will be turned down and send them to the state's high-risk pool. Other states that allow medical underwriting give insurance companies free reign to make decisions about who to accept, who to deny, and who to charge higher premiums.

Advance Review of Proposed Premium Rates

States that do not require prior approval of rates typically do require that insurers file their rates with the state insurance department for informational purposes under the "file and use" system. In some file and use states, the insurance department has authority to disapprove rates once they have gone into effect. We do not consider this as strong a protection as prior approval and so have not given states credit for it. However, readers should be aware that there is a lot of variation in state review authority and enforcement. State laws or regulations might specifically define criteria for rate review, broadly allow the insurance department to disapprove rates that are "unreasonable or discriminatory," or say that rates are filed "for informational purposes only." For more information, listen to the replay of the Families USA conference call, "Oversight of Health Insurance Prices," April 9, 2008, online at http://www.familiesusa.org/resources/tools-for-advocates/conference-calls-2008.html.

Limiting How Long Coverage Can Exclude Pre-Existing Conditions

Federal law limits how long coverage can exclude pre-existing conditions for people in employer-sponsored plans and prohibits pre-existing conditions exclusions for HIPAA-eligibles (discussed on page 23) who are joining designated individual plans. People who are moving from one individual coverage plan to another or who are buying coverage after being uninsured for more than 63 days are *not* protected by HIPAA. Our report findings deal specifically with individuals who are not protected by HIPAA.

For people joining employer-sponsored plans, pre-existing conditions are defined as any condition (except pregnancy) for which a consumer received medical advice, diagnosis, or treatment, or for which medical care was recommended, within the six months before he or she joined the plan. (That is, HIPAA allows a six-month look-back period and uses an objective standard for pre-existing conditions.) Some states have shortened the allowable look-back period in some health plans. Under HIPAA, new plans can exclude coverage of a pre-existing condition for no longer than 12 months for people who enroll in an employer-sponsored group plan (or 18 months for late enrollees in an employer-sponsored group plan). These periods are reduced for those who have had prior coverage without a 63-day break.

For example, if a person joins an employer-sponsored group health plan and has no prior coverage, that plan can refuse to cover that person's pre-existing condition for up to 12 months. However, if the person had three months of prior coverage without a gap of 63 days, the new plan can exclude coverage only for nine months (12 months - 3 months = 9 months).

Limiting the Look-Back Period

For people in the individual market who are not protected by HIPAA, there are no federal rules about pre-existing condition exclusions, and it is up to states to set limits. We gave states partial credit if they had a look-back period of no more than 12 months in the individual market and full credit if they restricted the look-back period to six months or less.

Using the Objective Standard to Define Pre-Existing Conditions

We did not give states credit if they used a "prudent person" standard for determining pre-existing conditions. That is, even though the person received no medical advice, based on a person's symptoms, the insurer thought that a prudent person would have sought advice, diagnosis, or treatment. The prudent person standard is subjective. It gives insurers a great deal of authority and leaves consumers, who have no knowledge of their future diagnosis, open to abuse.

Requiring Medical Underwriting Be Completed during Application

Many state laws are unclear as to whether insurers have to include written notices with insurance contracts about how long they are excluding specifically listed conditions, or whether insurers can just provide a general statement that allows them to determine later that a condition was pre-existing. We report regulators' answers to the question "Does the state require that insurers complete all medical underwriting at the time of application?", though we believe that some of the states' laws were ambiguous on this point.

After several cases in Connecticut in which insurers retroactively denied payment for serious illnesses, state lawmakers enacted Public Act 7-113 to require clear questions on insurance applications and notice to consumers about the importance of answering completely; set objective standards about pre-existing conditions that consumers must disclose (consumers must disclose treatment that has been received or recommended by a medical professional in the last two years); limit rescissions, coverage exclusions, and cancellations to two years after the policy was written; require that insurers submit proposed rescissions to the Insurance Commissioner for review; and give consumers appeal rights.

In California, statute already forbids insurers from rescinding, canceling, or limiting a policy that has already been issued unless plans show that an individual "willfully" omitted or misrepresented a medical condition in order to receive coverage. However, a number of recent California lawsuits allege that major health plans in the state systematically seek out innocent omissions and mistakes on applications and use these as a reason to cancel coverage after claims have been filed (Horton v. Wellpoint Inc, Cal. Super. Ct. No. BC 341823; Hailey v. Blue Shield of California, Cal. Ct. App. No. G035579, Ticconi v. Blue Shield of California Life and Health Insurance Co, Cal. Ct. App. No. B1904277/30/07). Over the past year, the Department of Insurance and the Department of Managed Health Care have each conducted investigations and fined insurers for wrongfully rescinding numerous policies.

To respond to these continuing problems, California proposed stronger regulations that would require insurers to ask clear questions on insurance applications, contact applicants or review additional health information to clarify any confusing or incomplete answers before issuing a policy, give consumers notice and the opportunity to participate in any investigations about whether they willfully misrepresented their health on applications, and provide for both internal and external appeals of rescissions. (At the time of this writing, these regulations had not yet been finalized.) California lawmakers also passed new legislation in 2007 to prevent insurers from refusing to pay providers for treatment that they have already authorized when policies are cancelled.

Laws about post-claims underwriting are not the full answer to addressing this abusive practice. As the experiences of consumers in California have shown, regulators must be vigilant in overseeing insurers' application procedures and must take action to enforce consumer protections. Even if there are not specific laws about post-claims underwriting in their states, consumers who believe that they have been the victim of abusive practices should find out if laws (on unfair and deceptive marketing, for example) might protect them. Nonetheless, states will have better tools to prevent and address abusive rescissions and denials of payment if they specify some ground rules.

Reviewing Insurers' Requests to Revoke Coverage

Guaranteed issue prevents insurers from revoking coverage, so for states with guaranteed issuance of all health insurance policies, we scored revocation requests and appeals as "not applicable" (NA). However, since these states do allow exclusions of pre-existing conditions, issues may still arise about insurers limiting coverage after claims are filed.

Accepting Appeals When Coverage Is Revoked

States generally contract with independent panels of medical experts to hear appeals about denials of care that the insurer thought was medically unnecessary or experimental. States may have different complaint or appeals processes for non-medical issues.

On our survey, we asked, "Does the state give consumers appeal rights if their policy is rescinded?" When states answered yes, we looked at their laws to see if that right was spelled out. Most states have a formal appeals process using a panel of medical experts for disputes about whether care is necessary. For other kinds of disputes on whether an insurer abided by state insurance regulations, states often use a less defined complaint process through the insurance department. We found that state laws are not crystal clear about what disputes are subject to the latter type of state review, so we reported the regulators' answer on this subject. Some state regulators indicated that although a formal appeals process does not exist, they would investigate consumer complaints. Because our survey question did not specifically ask about complaint processes, some state regulators may have responded "no" even though their states do have complaint processes.

Reviewing Denials for All State-Licensed Carriers

Consumers who have assistance through the appeals process from a knowledgeable advocate have a greater chance of succeeding. Some states have established consumer health assistance units through their attorneys general or through nonprofit organizations that help consumers present their cases. State insurance departments provide some guidance to consumers about how to file an appeal, but they may stop short of helping them gather evidence or present their cases.

Offering Free External Reviews Regardless of Claim Size

One state that requires consumers to pay filing fees for external appeals told us that the fees could be waived for those with financial hardship. However, since we did not ask other states if they also provided hardship waivers, we did not give credit for this.

TABLE NOTES

Require affordable coverage alternative for uninsurables?

- California regulators report that there is an estimated 3-4 month waiting list for enrollment in the high-risk pool.
- Oregon regulators report that the high-risk pool's income-based subsidy program is closed to new enrollees. However, individuals who are already enrolled in the high-risk pool and are already receiving subsidies will continue to receive them.

Prohibit higher premiums based on health status?

- Two states, Oregon and Washington, do not require insurers to accept all applicants, but premium increases based on health status are prohibited for those applicants they do accept. Some people can be rejected and are charged a higher premium in the state high-risk pool.

Advance review of proposed premium rates?

- Colorado passed a law in early May 2008 that implements prior approval of individual and small group market premium increases. However, the law was not on the books at the time of our survey (March 2008).
- According to state regulators, Mississippi is a prior approval state. However, statutes and regulations appear to limit regulators' review and approval powers.
- New York state regulators must approve new rate filings, but rate increases are file and use.

Require insurers to spend at least 75% of premiums on health care?

- Some states require carriers to meet a medical loss ratio for Medicare supplement and long-term care policies. These data are not included in the table.
- According to California's Department of Managed Health Care, for managed care plans, administrative costs must not be "excessive." A regulation limits administrative costs to 15-25 percent of premiums based on the developmental phase of the plan. However, administrative costs (defined in regulation) do not include some factors, such as salaries, stock options, etc. Thus, it is not a pure medical loss ratio in the classic sense.

Limit how long coverage can exclude pre-existing conditions?

- Texas regulators responded that, for individual insurance policies that used a simplified application (defined in 28 TAC §3.3002), losses due to pre-existing conditions (not excluded from coverage) must be covered after 12 months.

Limit look-back period?

- According to our survey respondents, in California, the look-back period is limited only for managed care plans regulated by the Department of Managed Health Care.
- In Connecticut, the limitation applies to most group and individual policies, but not to individual short-term policies issued on a non-renewable basis for six months or less (for those policies, there is an allowable look-back period of 24 months).
- In Michigan, a six-month look-back period applies to Blue Cross Blue Shield (the carrier of last resort) and HMOs. There is a 12-month look-back period for all other commercial carriers.
- In Nevada, there is no limit to how long insurers can look back into a person's medical history to put an exclusionary rider on his or her insurance policy. However, if the insurer has not asked about, or written an exclusionary rider about, a condition that requires treatment after the policy goes into effect, the insurer can only look back on the six-month period prior to the policy's effective date to determine if the condition was pre-existing.
- In North Carolina, there is a five-year limit (for products sold on a mass marketing basis) or no limit (on other products) on how long insurers can look back into an individual's medical history to identify exclusionary riders. However, if the insurer has not asked about, or written an exclusionary rider about, a condition that requires treatment after the policy goes into effect, the insurer can only look back at the six-month period prior to the policy's effective date to determine if the condition was pre-existing.
- In Oregon, a five-year look-back period applies for medical underwriting purposes (e.g. for determining the amount of the premium).

Use objective standard to define pre-existing conditions?

- According to the survey response from Vermont, no express standards have been established by state law or regulation, but federal standards are enforced. Although the objective standard appears to be used, there is nothing in statute requiring its use.

Require medical underwriting be completed during application?

- The California Department of Managed Health Care is in the process of finalizing stronger regulations regarding the practice of post-claims underwriting.
- Maine, Massachusetts, New Jersey, New York, and Vermont are states that guarantee issuance of all individual market policies to all applicants. Therefore,

insurers cannot revoke policies based on what they find in medical underwriting. Regulators in those states reported that the medical underwriting question does not apply because of guaranteed issue. However, all five states have pre-existing condition exclusion periods (of six months to one year), and medical underwriting is performed to identify pre-existing conditions. Absent explicit state protections, insurers can potentially identify a pre-existing condition after a policy is issued and deny claims.

- New Mexico recently enacted a law that enhances the burden of proof on insurers who claim policyholders made fraudulent misstatements on applications, which becomes effective on July 1, 2008, for comprehensive individual policies.
- Ohio regulators report that its unfair and deceptive marketing statute applies in this situation, requiring insurers to perform all medical underwriting at the time of application.

Accept appeals when coverage is revoked?

- According to California state regulators, appeal rights exist only for managed care products regulated by the Department of Managed Health Care.
- Georgia insurance regulators reported that perhaps there would be appeal rights for enrollees of HMOs.
- According to Idaho state regulators, appeal rights exist only for managed care organizations, not for other products.
- According to Minnesota regulators, appeal rights exist only for nonprofit health plans, not for commercial health plans.
- According to New Mexico regulators, appeal rights exist for managed care products.
- State regulators in Arkansas, Colorado, and North Carolina reported that they require insurers to have an appeals process, but they did not indicate that the department of insurance or another state entity offers an appeals process.

Review denials for all state-licensed carriers?

- Alabama regulators reported that the Consumer Complaint Board is an external review program of the Department of Health. We were unable to obtain information from the Alabama Department of Health regarding the scope, authority, related fees, or minimum claims thresholds.
- In Illinois, Indiana, and New Jersey, the external review entity makes a decision without further involvement from the state.

Make external reviewer decisions binding?

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Offer free external reviews regardless of claim size?

- Alabama regulators reported that the Consumer Complaint Board is an external review program of the Department of Health. We were unable to obtain information from the Alabama Department of Health regarding the scope, authority, related fees, or minimum claims thresholds.
- In Delaware, consumers appealing health plan denials that are based on medical necessity do not pay a filing fee. External reviews for other types of denials are subject to arbitration with a fee.

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