| ***State Preexisting Condition Definition Examples*** |
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| ***State*** | ***Definition*** |
| **Idaho** | **The definition below is from the Idaho administrative rule that corresponds to Model 171. It would be applied to all products within the scope of Model 171. The definition also appears in state law in the chapter applicable to individual health plans. Although the entire definition does not appear in the chapters applicable to group coverage, we would apply the same standards and allow for prudent person when reviewing those plan types.****Preexisting Condition**. Shall not be defined more restrictively than the following: a. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual’s coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than: i. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; ii. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or iii. A pregnancy existing on the effective date of coverage. b. A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage.c. An individual carrier shall not modify a health benefit plan with respect to an individual or dependent through riders, endorsements, or . otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. |
| **Texas** | The Texas statute regulating preexisting condition provisions is at [TIC §1251.108](https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1251.htm#1251.108). Based on subsection (b), we would not permit a group health plan to apply the “ordinarily prudent person” standard or provide for a look-back of more than 12 months. (We don’t have a statutory standard for individual plans.) Subsection (c) is similar to Section 7 of Model Act 170, and is separate from the definition being discussed for #171.Sec. 1251.108.  EXCLUSION OR LIMITATION OF COVERAGE FOR PREEXISTING CONDITIONS.  (a)  A group accident and health insurance policy must specify the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of an insured, not otherwise excluded from the insured's coverage by name or specific description effective on the date of the insured's loss, that existed before the effective date of the insured's coverage under the policy.(b)  An exclusion or limitation described by Subsection (a) may apply only to a disease or physical condition for which the insured received medical advice or treatment during the 12 months before the effective date of the insured's coverage.(c)  An exclusion or limitation described by Subsection (a) may not apply to a loss incurred or disability beginning after the earlier of: (1)  the end of 12 consecutive months, beginning on or after the effective date of the insured's coverage, during which the insured has not received medical advice or treatment in connection with the disease or physical condition;  or (2)  the second anniversary of the effective date of the insured's coverage. |
| **Kentucky** | **304.17A-220 Pre-existing condition exclusion in group coverage -- Definitions for section.**(6) For purposes of this section: (a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan; |
| **Kansas** | **We would like to ask subgroup members, regulators and interested parties to provide examples on how the term “Preexisting Condition” is defined within your state law. We would also like to see examples of how this definition is applied differently to various products that are applicable to Model #171.** Model #170 and Model #171 specifically exclude Medicare supplement and long-term care from applicability.#170 applies to individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity insurance, accident only, specified accident, specified disease, limited benefit health, and disability income protection, referred to collectively in Section 1 of this Act and hereafter, as “supplementary health insurance.” It also applies to short-term, limited-duration health insurance coverage, which, unless otherwise specified, is included in the definition of “short-term health insurance.” #171 applies to individual accident & sickness; group accident & sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage (hereafter referred to as “group supplemental health insurance.”) The regulation is also intended to assert the commissioner’s jurisdiction over dental and vision plans applies to all individual accident and sickness insurance policies and group supplemental health policies and certificates, delivered or issued for delivery in this state.**Kansas Statutes**K.S.A. 40-2209(a)(4)(E) : For the purposes of this section, the term "preexisting conditions exclusion" shall mean, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.K.S.A. 40-2209d (s): "Preexisting conditions exclusion" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period not to exceed 90 days following the insured's effective date of enrollment as to a condition, whether physical or mental, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received in the six months immediately preceding the effective date of enrollment.K.S.A. 40-2,193(a)(2): ) "Short-term'' means an insurance policy period of six months or 12 months, based upon policy design, which offers not more than one renewal period with or without a requirement of medical re-underwriting or medical requalification.K.S.A. 40-2203(A)(2)(b) “No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss has existed prior to the effective date of coverage of this policy.”**Kansas statutes as applied to Preexisting Definition from Model #171****Kansas statutes do not contradict the definition of a preexisting condition as outlined in Model #171. The Model states that preexisting conditions are the existence of symptoms causing a person to seek diagnosis or treatment or a condition for which medical advice is recommended or received from a physician within the two-year period prior to the effective date of coverage. This “look-back” period could be as far back as a company chose pursuant to their underwriting guidelines.****Lastly, we would like to ask for feedback on how Section 7 preexisting conditions, from Model #170, applies or does not apply to the definition of preexisting conditions under Model #171.**Section 7 from Model #170 has two definitions of preexisting conditions. Item 7A states that a policy shall cover any loss occurring after 12 months from any preexisting condition not specifically excluded from coverage. Item 7B states that a specified disease policy shall not deny a claim after six months of coverage unless loss results from a preexisting condition that first manifested itself within 6 months prior to the effective date of again.Model #171 only applies to the time period prior to the effective date of coverage and states that such look-back period for preexisting conditions shall not be more restrictive than 2 years.**Section 7A of Model 170 does not apply to #171 as it only applies to preexisting condition coverage after a policy has been in effective for 12 months. Section 7B of Model #170 does not apply as it also applies to coverage in effect for 6 months. However, Model #171 applies to 7A and 7B because the lookback period in #171 is contained in #170 as both 7A and 7B refer to preexisting conditions in existence prior to coverage becoming effective.** |
| **Washington** | 1. **“General” Health and Disability**
	1. RCW 48.43.005 (31) , WAC 284-43-0160 (32)  and WAC 284-170-130, all of which refer to traditional health and disability, define the term as:   “"Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.”
	2. WAC 284-50-315 (6), which exclusively applies to disability products, defines the term as :  "Preexisting condition" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five year period preceding the effective date of the coverage of the insured person.
2. **Long-Term Care**
	1. RCW 48.83.040 states that “A long-term care insurance policy or certificate may not define "preexisting condition" more restrictively than as a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person, unless the policy or certificate applies to group long-term care insurance under RCW 48.83.020(6) (a), (b), or (c).
	2. RCW 48.84.030 (3) defines the term as:  "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.”
	3. WAC 284-54-030 (17) defines the term as :  "Preexisting condition," as defined by RCW 48.84.020(3), means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.”
3. **Medicare Supplement**
	1. RCW 48.66.130 defines the term as:  “On or after January 1, 1996, a medicare supplement policy or certificate shall not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician, or other health care provider acting within the scope of his or her license, within three months before the effective date of coverage.”
	2. RCW 48.66.020 (8) defines the term as:  "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during a specified time period immediately prior to the effective date of coverage.”
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| **Vermont** | Pre-existing Conditions Definitions in Vermont LawThe following excerpts are from these materials:* Regulation 80-1, Accident & Sickness Minimum Standards
* 8 V.S.A. § 8086, the Long-Term Care statute
* Regulation 99-04, which governs community rating

(This pre-ex definition is out-of-use, superseded by PPACA)Accident & Minimum Standard Definition from Regulation 80-1 §5 (F)"Pre-existing Condition" shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment with a two (2) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician with a two (2) year period preceding the effective date of the coverage of the insured person.Long-Term Care Statute 8 V.S.A. §8086(a) No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.(b) No long-term care insurance policy or certificate may exclude coverage for a loss or confinement which is the result of a preexisting condition, unless such loss or confinement begins within six months following the effective date of coverage of an insured person.(c) The Commissioner may by rule extend the limitation periods established in subsections (a) and (b) of this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.(d) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (b) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (b) of this section. (Added 2003, No. 124 (Adj. Sess.), § 2, eff. Jan. 1, 2005.)Community Rating from Regulation H-1999-04"PRE-EXISTING CONDITION" means a condition that exists during the twelve-month period before the effective date of coverage.Examples of Definition of Pre-Ex from health supplemental health filings:1. “A disease or physical condition for which medical advice or treatment was received by the [Insured Person] during the 12 months prior to the [Insured Person’s] Coverage Effective Date under this [Certificate].]”2. “Pre-existing Condition means a sickness or physical condition for which, during the 12 months before this rider’s Issue Date or last Reinstatement Date, the Insured Person received medical consultation, Diagnosis, advice or Treatment from a Physician or had taken prescribed medication.”3. “Pre-existing Condition A condition, whether diagnosed or not, for which symptoms existed which would cause a reasonable person to seek diagnosis, care or treatment within the 12-month period prior to the Effective Date; or for which medical advice or treatment HII M 119 C 9 was recommended or received from a Physician within the 12-month period prior to the Effective Date.”4. “Pre-existing Condition(s) means a condition for which medical advice, Diagnosis, care or treatment was recommended or received within the 12 month period before the Covered Person’s Rider Effective Date. A Pre-Existing Condition is excluded from coverage for period of [6-24] months following the Covered Person’s Rider Effective Date. If the Covered Person is Diagnosed with a condition listed in this rider that is determined to be a Pre-Existing Condition, no benefit amount is payable for that listed condition. We may have the Covered Person examined by a Physician of Our choosing at Our expense.”5. “Preexisting Condition means a condition for which: (1) medical advice or treatment was recommended by or received from a Medical Practitioner within the one-year period before the Coverage Effective Date; or (2) symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment.” |
| **Maine** | For the types of coverage primarily within the scope of Models 170/171, Maine law follows Model # 171 and defines what is **not** a preexisting condition, by limiting how broadly a carrier can define the term contractually: “’Preexisting condition’ shall not be defined more broadly than the following: ‘Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care, or treatment within a 24-month period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 24-month period preceding the effective date of the coverage of the insured person.’”  Bureau of Insurance Rule 755, § 4(K).24-A M.R.S. § 2850(1-A)(B) defines preexisting condition **exclusion**, but that definition appears in a section that does not apply to limited-benefit plans: “’Preexisting condition exclusion,’ with respect to coverage, means a limitation or exclusion of benefits relating to a condition based on the fact or perception that the condition was present, or that the person was at particularized risk of developing the condition, before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.”  Strictly speaking, therefore, our limitation on preexisting condition exclusions for limited-benefit plans, 24-A M.R.S. § 2696, leaves the term undefined, but the major medical definition quoted above fits the plain-language meaning of the term.<http://legislature.maine.gov/legis/statutes/24-A/title24-Asec2696.html>   |

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