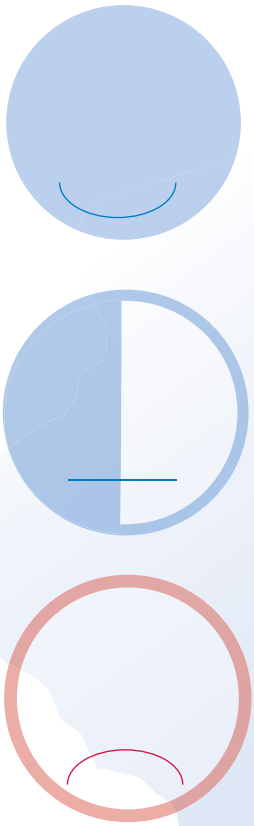

Failing Grades:

Illinois Fails to Protect Consumers In the Individual Health Insurance Market

Families USA

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Introduction

Without adequate consumer protections, the individual health 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. Unlike the insurance market for employers—in which federal law has established a set of basic protections—the task of protecting consumers in the individual market has, for the most part, been left to the states. The result is a patchwork of protections that are inadequate as a whole and that vary greatly from state to state.

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 also examined Illinois specifically in order to identify any inadequacies in state law that leave consumers vulnerable to insurance company abuse. Based on our findings, we have made several policy recommendations for private market reform in Illinois.

Findings

- In Illinois, insurance companies in the individual market are permitted to reject people for coverage based on their health status and other factors.
  - The only plan that must accept individuals with pre-existing conditions is the state's high-risk pool. However, premiums in the high-risk pool can be up to 50 percent higher than the premiums charged to other people in the private market, and there are no income-based subsidies available to help consumers pay for this costly coverage.
- If an insurance company does accept an individual's application for coverage, Illinois does not limit how much the insurer can vary the premium based on what the insurer deems to be health risks (which can include anything from cold sores to being below average height).
- Insurance companies in Illinois are allowed to exclude coverage for the very health services that individuals need when they sign up for a policy: Insurers in the state can exclude coverage for pre-existing conditions for two years.[1] They can also attach "elimination riders" to policies, which permanently exclude coverage for specific health conditions or services.
- In Illinois, insurers can set and raise premiums without adequate oversight. The state does not ensure that premiums are reasonable by reviewing premium rate increases before insurance companies impose them. In addition, insurance companies in the state are allowed to spend less than 75 cents of every premium dollar on medical services.

- Insurance companies in the state can limit or revoke an individual's policy long after it was purchased by claiming that the policyholder did not adequately reflect his or her medical history on the application. Oftentimes, this leaves individuals with huge medical bills that must be paid out of pocket.
  - Insurers in Illinois are allowed to look at a policyholder's medical history and perform medical underwriting up to two years after they issued the policy. (Medical underwriting is the process of reviewing an applicant's medical history using his or her application and medical records to determine premiums and coverage exclusions.)
  - Insurance companies can revoke an individual's health insurance policy without advance review by the state.

In Illinois, approximately 512,000 people (about 4.6 percent of the state's total population) have coverage through the individual market. An additional 1,731,000 people in the state (about 15.5 percent of the state's population) are uninsured.[2]

People may end up in the individual health insurance market for a variety of reasons. Some employers require employees to pay most or all of the premium to enroll in the firm's health benefits, and this share may be more than workers (especially low-wage workers) can afford. Many employers, especially small firms, do not offer health benefits to employees at all.

While federal law protects individuals who leave a job and therefore lose their employer-based health coverage, these protections are somewhat limited.[3] For example, if an individual does not obtain new coverage within 63 days, he or she will not be covered by these federal protections when searching for coverage in the individual market. Furthermore, there are few federal protections for people once they have coverage in the individual market. For example, people with individual health insurance who decide to switch plans—because their premiums have increased too much, or because they need more comprehensive benefits—are liable to be denied coverage or charged more based on their pre-existing conditions.

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 health care. ◐ State requires some insurers to spend at least 75% of premiums on health 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 for which a medical professional diagnosed or recommended treatment. ○ 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	○	○	○

Discussion

In order to better understand what Illinois health care consumers face when they are looking for coverage in the individual market, we have divided the state's insurance protections into the following categories:

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

Availability of Coverage

Question: Are insurers required to sell coverage to all who apply?

While employers are guaranteed the right to purchase group health insurance, federal law does not guarantee individuals the right to purchase the policy they choose.[4] Insurers can refuse to sell policies to individuals based on their health, recreational activities, occupation, credit history, and a variety of other factors.[5]

One national study found that 21 percent of adults seeking coverage in the individual market were turned down, charged a higher-than-average premium, or offered a plan that excluded coverage of a specific health problem. One-third of adults with a health condition who sought coverage in the individual market were turned down, charged a higher premium, or offered a plan that excluded coverage of a specific health problem.[6] People may be denied coverage merely because they take common drugs like Celebrex (for arthritis pain), Lipitor (for high cholesterol), or 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.[7]

Illinois does not have a **guaranteed issue** law, which would require insurance companies to sell all policies to everyone who applies. Insurers are permitted to cherry-pick the healthiest applicants and reject individuals with pre-existing conditions.

People who are denied coverage in the individual market may enroll in the state's **high-risk pool**. This pool, known as the Illinois Comprehensive Health Insurance Plan (ICHIP), is a nonprofit association that provides coverage for people who have been turned down by individual market insurers because of high-risk health conditions. However, ICHIP charges premiums that can be as much as 50 percent higher than the premiums charged to other people in the private market, which makes the program unaffordable for many

consumers. Furthermore, there are no income-based subsidies to help individuals pay for ICHIP coverage. Not surprisingly, ICHIP covers just 16,700 people, and the state has about 1.7 million uninsured.[8]

To make high-risk pools truly affordable, accessible coverage alternatives for individuals with pre-existing conditions, states should limit high-risk pool premiums to at most 25 percent higher than the premiums charged to other people in the private market. They should also offer income-based subsidies to help individuals pay for this coverage.

Findings

- **Guaranteed issue:**
  - **All states:** Five states require guaranteed issue, meaning that all insurance companies are required to sell all policies to all individuals who apply, regardless of their health status.[9]
  - **Illinois:** Illinois does not have a guaranteed issue law. The state allows insurers to deny coverage based on an individual's pre-existing conditions.
- **High-risk pool premiums and income-based subsidies:**
  - **All states:** Eleven states' high-risk pools offer premiums that are no more than 25 percent higher than the premiums charged to other people in the private market, and 13 states provide additional income-based subsidies to enrollees.[10]
  - **Illinois:** Illinois's high-risk pool does not offer premiums that are no more than 25 percent higher than the premiums charged to other people in the private market, and it does not offer income-based subsidies.

Policy Recommendations

Illinois should make health coverage more accessible to individuals regardless of their health status or occupation by requiring all insurance companies to take all applicants—a requirement known as guaranteed issue. Evidence from one state that keeps data shows that only a small percentage of eligible individuals enrolls in the state's high-risk pool.[11] High-risk pools are helpful to some, but consumers should be able to pick the plan that best suits their needs, rather than being limited to the high-risk pool.

As an alternative to requiring guaranteed issue, Illinois could strengthen the regulation of underwriting practices in the individual market and improve its high-risk pool to make it significantly more accessible. Such changes would include the following:

- Standardize the application forms and medical underwriting criteria among individual market insurers to prevent insurers from rejecting applicants who are not, in fact, high-risk, as Washington does. The new underwriting criteria may include a list of health conditions that are grounds for denial.
- Cap the high-risk pool premiums at no more than 25 percent higher than the premiums that are charged to others in the private market. In California, Minnesota, and Oregon, state regulations limit high-risk pool premiums to no more than 25 percent higher than standard premium rates. Connecticut, Idaho, Indiana, Maryland, Missouri, Montana, New Hampshire, and Washington reported having at least one product priced within this range, even in the absence of law or regulation.
- Offer income-based subsidies to individuals who seek high-risk pool coverage, as is done in Colorado, Connecticut, Indiana, Maryland, Minnesota, Montana, New Mexico, Oregon, Tennessee, Utah, Washington, Wisconsin, and Wyoming.[12]
- Shorten the waiting period for coverage of previously uninsured high-risk pool enrollees' pre-existing conditions.

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 Illinois, 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 him or her with no affordable coverage options.

Some states protect consumers by prohibiting insurance companies from looking at individuals' health when determining premiums. Other states have established 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[13] based on that applicant's health.

Findings

- **All states**: Seven states prohibit insurers from charging higher premiums based on health status.[14]
- **Illinois**: Illinois does not prohibit insurers from charging higher premiums based on health status.

- **All states:** Two states limit insurance companies to varying premiums based on health status by 25 percent.[15]
- **Illinois:** Illinois has no limits on how much insurers can vary premiums based on individuals' health status.

Policy Recommendations

Illinois should prohibit insurance companies from setting premiums based on individuals' health status and limit the amount that insurers vary premiums for other factors (such as occupation and age), a system called modified community rating. Setting premiums based on individuals' health status defeats the purpose of insurance, which is designed to spread risk widely among people with different risk profiles. When insurers are permitted to set premiums based on how unhealthy an individual may appear on his or her application, they are not sharing risk among policyholders. The financial burden of a much heftier premium is often too great to bear for people with pre-existing conditions, and many are unable to afford coverage. This creates a dysfunctional market.

An incremental approach to addressing this problem is to introduce rate bands that limit to 25 percent or less how much insurers can vary premiums based on health. This step would begin to move the state away from the problematic variations in premiums that exist in Illinois's unregulated market while promoting greater risk-sharing.

Question: Are consumers protected from excessive premiums?

In Illinois, insurance companies can set premiums and raise premium rates without state insurance regulators intervening on behalf of individual policyholders. However, many states do have the jurisdiction to oversee insurance companies' premium increases by requiring insurers to submit proposed premiums and proposed premium 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 premiums until the state department of insurance has had a given number of days to review the premiums and approve or deny them. In addition, many states will accept requests to increase premiums only once a year.

States report that they receive outlandish proposals from insurance companies to increase premiums by as much as 100 percent. 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 these premiums and stop those that are excessive.

Findings

- **All states**: Twenty-five states give the insurance department the authority to approve premium rates for all individual health insurance plans prior to the premiums going into effect.[16]
- **Illinois**: Illinois insurance regulators do not have the authority to approve or disapprove premium rates before they go into effect.

Policy Recommendation

Illinois should require insurers to submit requests for both setting and increasing premiums with the Division of Insurance. Requests should be permitted no more than once per year, and insurers should be required to prove that premium increases are necessary and that they are not based on policyholders' health status.

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

Illinois has no protections in place that ensure that the premiums paid by consumers who are buying coverage in the individual market will be used for medical services rather than for insurance company administration, advertising, and profit. Without adequate consumer protections, insurance companies sometimes spend only 60 cents of every premium dollar on actual health care.[17]

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 a high enough percentage of premium dollars on medical care, it must either refund money to 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 helps hold insurance companies accountable.

Insurance companies should be required to spend a reasonable portion of premiums on medical care, and they should not be making high profit margins at the expense of consumers. In New Jersey, a new law has raised the medical loss ratio for individual market insurers, requiring them to meet an 80 percent medical loss ratio (up from 75 percent), and it provides refunds to policyholders annually if insurers fail to spend 80 cents of every premium dollar on medical services. Currently, several states (such as California 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 hard-earned money.

In states that have enacted minimum medical loss ratio standards, there have been significant savings for consumers. As a result of Maine's small group market medical loss ratio requirement (which is 75 percent for insurers that agree to participate in the state's hearing process for reviewing premiums, or 78 percent for insurers who opt out of the hearing process), in 2008, one Maine insurance company will refund policyholders $6.6 million, and another will refund policyholders $1 million. In New Jersey, between 1993 (when the state implemented the 75 percent medical loss ratio in the individual market) and 2006, insurers that failed to meet the requirement refunded a total of $11.6 million dollars to consumers. In late May 2008, New York's Governor and Department of Insurance announced that Oxford Health Insurance would refund $50 million to 37,000 small businesses in the state because, in 2006, the company did not achieve the state's 75 percent minimum medical loss ratio.

Findings

- **All states:** Five states require some or all insurance companies to meet at least a 75 percent minimum medical loss ratio.[18]
- **Illinois:** Illinois does not require insurers in the individual market to spend at least 75 cents of every premium dollar on medical care.

Policy Recommendation

The state should institute and enforce a minimum medical loss ratio of 85 percent. Meeting the medical loss ratio should be one of the criteria that the Division of Insurance uses to evaluate insurance companies' requests for premium increases.

Pre-Existing Conditions

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

Pre-existing conditions are health problems that individuals already had when they purchased coverage. For example, if an individual had a heart condition before buying an insurance policy, that policy could refuse to cover heart attacks that occur within a certain period of time after enrollment (six months, for example), or the policy might not cover heart attacks at all.

Even when people are able to find affordable coverage in the individual market, this coverage may not meet their immediate health needs because their pre-existing conditions are not covered. Illinois insurance companies are allowed to exclude coverage for the treatment of pre-existing conditions for two full years.[19] Illinois also allows insurers to sell policies that contain **elimination riders**—contractual clauses that state that the insurer will never cover an individual's treatment for a specific pre-existing condition.[20]

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.[21] And 13 states prohibit insurers from selling policies that contain elimination riders.[22]

Another important consumer protection that some states have adopted 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. Illinois allows insurance companies to look back at two years of an individual's medical history to determine what pre-existing conditions they will exclude from the policy. Some states limit the look-back period to six months or one year.

In order to protect consumers, some states use what is called the objective standard, which 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. Some states leave consumers vulnerable to abuse by allowing insurance companies to use the prudent person standard to determine what pre-existing conditions they will exclude from coverage. The prudent person standard considers a pre-existing condition to be something for which a "prudent person" would have sought treatment. This standard permits insurers to broadly interpret medical records in order to exclude certain medical services.

A case from Connecticut illustrates the problem with using the prudent person standard: An insurance company rejected claims from a 34-year-old woman who was diagnosed with Hodgkin's lymphoma one month after her policy began. In a medical visit after enrolling, she recalled having mild shortness of breath while exercising six months before the visit. The insurer said the symptom constituted a pre-existing condition and should have caused her to seek treatment before enrollment, even though her shortness of breath was unrelated to her diagnosis.[23]

Illinois law does not do enough to protect consumers from this type of abuse. It requires insurers to use an objective standard to determine any pre-existing conditions that an individual has developed during the two years prior to application. However, for two years after an individual has obtained a policy, the insurance company is allowed to use the prudent person standard to investigate the 12 months preceding enrollment and exclude coverage for conditions for which a prudent person would have sought treatment.

Findings

- **Pre-existing condition exclusion period and elimination riders:**
  - **All states:** Twenty-seven states limit the pre-existing conditions exclusion period to nine or 12 months, and two states limit the pre-existing conditions exclusion period to six months or less. Thirteen states prohibit insurers from selling policies that contain elimination riders, which permanently exclude coverage for specific pre-existing conditions.[24]
  - **Illinois:** Illinois allows insurers to exclude coverage of a pre-existing condition for two years. The state also allows individual market insurers to add elimination riders.[25]
- **Look-back period:**
  - **All states:** Fifteen states limit to six months or less how far insurers can look back into an individual's medical history to define coverage exclusions. Ten states limit to 7-12 months how far insurers can look back into an individual's medical history to define coverage exclusions.[26]
  - **Illinois:** Illinois allows insurers to look back up to two years into an individual's medical history to define coverage exclusions.
- **Definition of pre-existing condition:**
  - **All states:** Eighteen states use an objective standard to define pre-existing conditions.[27]
  - **Illinois:** Illinois allows insurers to use the prudent person standard, which defines a pre-existing condition as a condition for which a prudent person would have sought medical attention.[28]

Policy Recommendations

Illinois should limit to six months how long individual market insurers can exclude coverage for pre-existing conditions—two years is an excessively long waiting period. Further, Illinois should shorten the pre-existing condition exclusion period for people who had previous coverage from another insurer. The state should also prohibit insurers from investigating more than six months of an individual's medical history to find pre-existing conditions. Finally, it should require insurers to define pre-existing conditions that consumers must disclose on their applications for insurance as treatment that has been received or recommended by a medical professional within the last six months. 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.

Coverage Revocations

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 Illinois, individuals are at risk of seeing their health coverage evaporate before their eyes, leaving them with devastating 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 Illinois, when people apply to purchase individual health insurance, insurers can ask 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 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 (tacitly—if not explicitly) allow 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**. Illinois regulators report that they do not require insurers to complete all medical underwriting at the time of application, which means that the state allows the practice of post-claims underwriting.

In states where post-claims underwriting is allowed, insurance companies can dig further into individuals' medical histories and retroactively limit coverage long after policies were purchased, often right when costly medical treatment is needed. Insurers may even try to revoke coverage, claiming that individuals should have known about their health condition before they bought policies. Consumers are then shocked to find themselves without coverage.

A handful of states have begun to address these abuses by prohibiting insurers from performing post-claims underwriting. Some states have also opened up appeals processes for consumers facing situations like these. One state has also required that insurers submit a request to state regulators if they want to revoke an individual's policy, explaining how the individual misrepresented his or her health on the application for coverage.

Findings

- **Complete underwriting at time of application:**
  - **All states:** Thirteen states report that they require insurers to complete all medical underwriting and resolve all questions at the time of application. 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.[29]
  - **Illinois:** Illinois does not require insurers to complete all medical underwriting and resolve all questions at the time of application.
- **State permission required to limit or revoke coverage:**
  - **All states:** 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.[30]
  - **Illinois:** Illinois allows insurers to limit or revoke coverage of individual policyholders without the state's review.
- **Appeal rights:**
  - **All states:** Eighteen states and the District of Columbia report that they give consumers appeal rights if their policy is revoked. An additional eight states have no formal appeals process, but they report that they investigate consumer complaints if coverage is revoked.[31]
  - **Illinois:** Illinois reports that it gives consumers appeal rights if their policy is revoked.

Policy Recommendations

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

- Require insurers to present clear questions on insurance applications and to communicate the importance of providing complete answers.
- 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.

- Insist that insurers revoke policies only under exceptional circumstances when the insurer can demonstrate *willful misrepresentation and intent to deceive*.
- Prohibit insurers who revoke policies from refusing to pay providers for treatment that the insurers have already authorized after policies are cancelled.
- Require that insurers submit requests to revoke policyholders' coverage to the 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.

Enforcement of Rights

Question: Are consumers protected if their insurance company refuses 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 these things to ensure that policyholders are receiving treatment that is medically necessary and effective. However, an insurer's bottom line benefits when medical claims are fewer and cheaper, which provides a financial incentive to deny services that may greatly benefit the health of the policyholder.

Along with many states, Illinois has established a program in which an objective third party evaluates disputes between insurance companies and policyholders over service denials, called **external review**. The program provides a crucial consumer protection that allows consumers with policies in the individual market to contest decisions made 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 the reviews that were conducted by health plans.[32] 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. However, Illinois's external review program is available only to consumers in managed care, meaning that many Illinois consumers do not have the right of external review.

Only a small number of consumers use the external review process. 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, the small number of external reviews could indicate weaknesses in consumer protections, such as the following:

- consumers never find out about the formal appeals process,
- consumers give up on their cases during negotiations before they get to an appeal, or
- consumers cannot successfully appeal because their state does not have any rules to protect them against insurance company abuses (such as excessive premiums, pre-existing condition exclusions, and policy revocations).

While external review is an essential protection for people who are denied crucial medical services, states should do much more to protect consumers.

Findings

- **All states**: Thirty-six states have external review requirements for all state-licensed plans.[33]
- **Illinois**: Illinois has an external review process, but it does not apply to all state-licensed plans.

Policy Recommendation

Illinois should expand the external review program to be available to consumers in all types of health plans. Utilization review is widespread, and individuals need appeal rights beyond those available within their plan to fight service denials whether they are in a managed care plan or another type of health plan.

Conclusion

Based on our criteria, Illinois currently fails to provide consumers with many basic protections in the individual health insurance market. These failures represent vulnerabilities for consumers who may be treated unfairly by insurance companies and who have little recourse. We recommend policy changes that would:

- Guarantee access to an affordable coverage option to consumers in the individual market through **guaranteed issuance** of all individual health insurance policies to all individuals who apply for coverage; or by enacting significant reforms to the state's coverage alternative for people with pre-existing conditions, the **high-risk pool**.
- Limit how much insurance companies can charge people based on their health by using **modified community rating** or establishing restrictions on rate variations based on health status.
- Implement greater oversight of premium increases in the individual market by requiring insurers to seek **prior approval** before increasing premiums.
- Require insurers to use premium dollars efficiently by implementing a **minimum medical loss ratio** requirement.
- Reduce how long individuals must wait for coverage of pre-existing conditions, limit how far back insurers can look at an individual's medical history (the **look-back period**) to identify pre-existing conditions, and require insurers to use the **objective standard** to define such conditions.
- Prevent insurers from abusing loopholes in order to eliminate benefits or revoke coverage, a practice known as **post-claims underwriting**.
- Provide all individual market consumers with the same rights to a third-party review (known as **external review**) if insurers deny services.

Endnotes

[1] 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 July 23, 2008.

[2] Kaiser State Health Facts Online, *Health Insurance Coverage of Nonelderly (0-64), States (2005-2006), U.S. (2006)*, available online at http://www.statehealthfacts.org/comparetable.jsp?ind=126&cat=3&sub=39&yr=1&typ=2, accessed on August 8, 2008.

[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 their 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] Ibid.

[5] 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, 2007), available online at http://www.opic.state.tx.us/docs/442_2007_health_ug.pdf.

[6] *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (Washington: Commonwealth Fund, September 2006).

[7] 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.

[8] "State Population and Uninsured Rates" and "Pool Membership – 2006," *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis* (Denver: National Association of State Comprehensive Health Insurance Plans, 2007).

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

[10] Through regulation, three states cap premiums at no more than 25 percent higher than standard premiums: CA, MN, and OR. Eight additional states reported having at least one product that is priced within this range, even in the absence of law or regulation: CT, ID, IN, MD, MO, MT, NH, and WA. Thirteen states offer income-based subsidies: 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.

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

[12] Subsidy programs may be more meaningful in some states than in others. We did not attempt to evaluate the differences in subsidy programs.

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

[14] 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 they do not require insurers to accept all applicants.

[15] MN and NH.

[16] 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.

[17] 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 medical loss ratio. Based on Families USA interviews with health insurance regulators in 19 states in December 2007 and January 2008.

[18] NJ, NY, and WA require all insurers in the individual market to meet a 75 percent minimum medical loss ratio. NV and VT require some insurers in the individual market to meet a 75 percent minimum medical loss ratio.

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

[20] Kaiser State Health Facts Online, *Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals), 2007*, op. cit.

[21]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.

[22] Kaiser State Health Facts Online, *Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals), 2007*, op. cit.

[23] *Testimony before the House Committee on Oversight and Government Reform*, Kevin Lembo, State Healthcare Advocate, Connecticut, July 17, 2008, available online at http://oversight.house.gov/documents/20080717101819.pdf.

[24] 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 allow either a nine-month or 12-month exclusion of pre-existing conditions. MA and NM allow a six-month exclusion of pre-existing conditions. The following states prohibit insurance companies from selling policies containing elimination riders: CA, ID, IN, KY, ME, MA, MI, MN, NJ, NY, OR, VT, and WA.

[25] Kaiser State Health Facts Online, *Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals), 2007*, op. cit.

[26] ID, KY, MA, MN, NH, NJ, NM, NY, ND, OH, OR, UT, VT, WA, and WY limit the look-back period to six months. CA, CO, CT, IN, LA, ME, MI, MS, SD, and VA limit the look-back period to 7-12 months.

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

[28] Illinois law requires insurers to use an objective standard to determine any pre-existing conditions at the time of application. However, for two years after an individual has obtained a policy, insurers are allowed to use the prudent person standard to investigate the 12 months preceding enrollment and exclude coverage for conditions for which a prudent person would have sought treatment. This loophole appears to undermine the requirement of using the objective standard at the time of application.

[29] CA, CO, CT, FL, IN, MD, NH, NM, OH, PA, RI, VA, and WA report they require insurers to complete all medical underwriting at the time of application. AL, NE, and OR 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.

[30] CT.

[31] CA, CT, DC, FL, ID, IL, IN, LA, MD, MN, MO, MT, NE, NV, NM, OR, RI, WA, and WI report that they give consumers appeal rights if their policy is revoked. Eight states report that they have no formal appeals process but that they investigate consumer complaints if coverage is revoked: KY, MI, ND, OK, SC, SD, TN, and TX. Since our survey did not explicitly ask about complaint investigations, additional states may fall into this latter category.

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

[33] 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.

Methodology

Families USA surveyed all state departments of insurance and high-risk pool 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, and 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/external-reviewpart2rev.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.

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