



INSURANCE DIVISION M E M O R A N D U M

June 7, 2006

To: All Health Insurance Carriers

From: Joel Ario, Insurance Administrator

Subject: Use of health questionnaires for determining health status of individual enrollees or employer groups prior to enrollment

The Oregon Insurance Division has recently reviewed “Large Claim Disclosure Forms” and “Risk Evaluation Questionnaires” used by certain health insurance carriers for the stated purpose of “underwriting and rating” and to determine “final rates and acceptance of the group” of employer groups applying for group health insurance.

The Oregon Insurance Code expressly prohibits the use of “health statements or other information” until after enrollment of an employer group (other than small employer groups). Even after enrollment only “aggregate” group information related to historical medical claims expenses and health behavior surveys may be used for rating purposes. Additionally, carriers are expressly prohibited from using any method to determine the actual or expected health status of an eligible prospective enrollee.

It is a violation of the Insurance Code to use information received or requested from a prospective employer by use of statements, including those in Attachment A, which identify prior claims or expected or anticipated health care treatments, procedures, or claims to determine the actual or expected health status of a prospective enrollee, at anytime, or of the group as a whole prior to enrollment (i.e. prior to offering group health benefit plans).

Further, asking these or other health status related questions prior to enrollment with the caveat that the employer “not provide any information identifying the individual” is a violation of the Oregon Insurance Code as the Code prohibits use of any method “to determine the actual or expected health status of eligible prospective enrollees.” The Code does not allow determinations of health status of eligible prospective enrollees simply because the enrollee is not “identified by name, address, or member number.”

Additionally, using such statements for the purposes of providing rates to prospective employers which effectively act as a rejection of the group is a violation of the Insurance Code. (Please refer to statutory reference in Attachment B.)

Attachment A
Examples of prohibited pre-enrollment questions

1. To the best of your knowledge are you aware of any employee, dependent, or COBRA participant:
 - a. Who has been diagnosed or treated for any of the following conditions in the past 3 years? (List of medical conditions)
 - b. Who is currently disabled or receiving ongoing care for a medical disability?
 - c. Who is currently hospitalized or who is anticipating hospitalization or surgery within the next 60 days?
 - d. Who has missed more than 10 consecutive days of work in the past 12 months due to illness or injury?
 - e. Who is currently pregnant?
 - f. Who has accumulated claims in excess of \$25,000 in the past 12 months?
 - g. Who has a history of requiring frequent medical treatment?
 - h. Who has an autistic or otherwise psychiatrically disabled dependent?
 - i. If you answered yes to any questions, please provide the following details: employee or dependant, gender, age, nature of illness, dates of treatments, claim dollars spent, current "health status."
2. Please describe any circumstance, (including any illness or injury on the part of an employee or dependent) of which you are aware, that might lead to a potential large claim in the next plan year.

Attachment B
Statutory References

ORS 743.751 Health statements; permissible uses

- (1) Except to determine the application of a preexisting conditions provision for a late enrollee, a carrier offering group health benefit plans shall not use health statements when offering such plans to a group of two or more prospective certificate holders and shall not use any other method to determine the actual or expected health status of eligible prospective enrollees. Nothing in this section shall prevent a carrier from using health statements or other information **after enrollment** for the purpose of providing services or arranging for the provision of services under a health benefit plan or from obtaining aggregate group information related to historical medical claims expenses and health behavior surveys for rating purposes.
- (2) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans.

ORS 743.752. Coverage in group health benefit plans; consideration of prospective enrollee health status restricted; effects of discontinuing offer of plans; coverage by multiple employer welfare arrangements

- (1) Except in the case of a late enrollee and as otherwise provided in this section, a carrier offering a group health benefit plan to a group of two or more prospective certificate holders shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.
- (2) ****
- (3) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans.
- (4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that does not relate to the actual or expected health status of the employees or their dependents.

Pre-existing conditions provisions in group plans limited to conditions in six-month period preceding enrollment.

ORS 743.754. Requirements for group health benefit plans and for discontinuation of plans

The following requirements apply to all group health benefit plans covering two or more certificate holders:

- (1) A preexisting conditions provision in a group health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or

received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

- (2) A preexisting conditions provision in a group health benefit plan shall terminate its effect as follows:
 - (a) For an enrollee not later than the first of the following dates:
 - (A) Six months following the enrollee's effective date of coverage; or
 - (B) Twelve months following the start of any required group eligibility waiting period.
 - (b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.
- (3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all group benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new group health benefit plan.