

Pre-existing Conditions

What are pre-existing conditions?

A pre-existing condition is a medical condition diagnosed or treated prior to applying for or enrolling in a new health plan. In some cases, an insurance company can deny coverage or place exclusions on your policy because of a pre-existing medical condition. The laws that govern how an insurance company must consider a pre-existing condition are outlined in the [Health Insurance Portability and Accountability Act of 1996](#). (HIPAA)

Basically, this law states that an insurance company may not exclude treatment for a pre-existing medical condition if the new enrollee has had continuous health insurance coverage for at least six months prior to acquiring the new health plan. Any length of time that the insured has had previous coverage will be applied to this six month waiting period. The laws that govern HIPAA regulations may vary from state to state. Refer to the HIPAA regulations on the website of your [State Department of Insurance](#) for additional information.

Also, it is important to keep in mind that this law does not require the insurance companies to insure you when you are applying for a standard issue individual health insurance plan. Most states allow the insurance companies to decline applicants for individual health insurance, based on their current and past health history. Most group health plans are guaranteed issue, so the pre-existing exclusions governed by HIPAA regulations pertain more to persons acquiring new health insurance under an employer sponsored group health plan.

For individual health plans, some insurance companies may place an "exclusionary rider" on a policy that states the insurance company is not responsible for paying benefits on pre-existing conditions. The insurance company will only approve the application for coverage if the exclusionary rider is signed by the applicant.