114th MAINE LEGISLATURE

SECOND REGULAR SESSION - 1990

Legislative Document **No. 2250**

S.P. 880 In Senate, January 29, 1990

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 24.

Reference to the Committee on Banking and Insurance suggested and ordered printed.

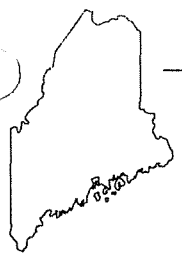
JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator COLLINS of Aroostook.
Cosponsored by Representative DONALD of Buxton, Senator THERIAULT of Aroostook and Representative ALLEN of Washington.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

An Act Concerning the Discontinuance and Replacement of Group Health Insurance.



Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2330-A is enacted to read:

§2330-A. Discontinuance and replacement of group coverage

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Group" means any of the types of groups defined in Title 24-A, sections 2804 to 2808.

B. "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

2. Extension of benefits. The following extension of benefits applies to coverage that is discontinued.

A. Every group contract, executed, delivered, issued for delivery, amended, continued or renewed on or after the effective date of this section, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group contract or discontinuance of coverage for a subgroup in the contract as required by paragraphs B, C and D.

B. In the case of hospital or medical expense coverages, other than dental expense, a reasonable extension of benefits provision is required. A provision is considered "reasonable" if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance.

C. Any applicable extension of benefits must be described in any contract or group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the contract. A premium may not be changed during the period of extension.

D. After discontinuance, the carrier remains liable only to the extent of its accrued liabilities and extensions of benefits.

3. Continuance of coverage in situations involving replacement of one carrier by another. This subsection indicates the carrier responsible for liability in those instances when a contract of one carrier replaces a health care benefit plan of another carrier for a group or subgroup.

A. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier is the same whether the group contract holder or other entity secures replacement coverage from a new carrier, self-insures or foregoes the provision of coverage.

B. The liability of the succeeding carrier is as follows.

(1) Each person who is eligible for coverage in accordance with the plan of benefits of the succeeding carrier is covered by the plan of benefits of that carrier.

(2) Each person not covered under the plan of benefits of the succeeding carrier in accordance with subparagraph (1) shall be covered by the succeeding carrier in accordance with the following rules if the individual was covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class or classes of individuals eligible for coverage under the plan of the succeeding carrier. In the following provisions, any reference to a disabled individual is a reference to the status of the individual immediately prior to the date the coverage of the succeeding carrier becomes effective.

(a) The minimum level of benefits to be provided by the succeeding carrier is the applicable level of benefits of the plan of the prior carrier reduced by any benefits payable by the prior plan.

(b) Coverage must be provided by the succeeding carrier until the earliest of the following dates:

(i) The date the individual becomes eligible under the plan of the succeeding carrier as described in subparagraph (1);

(ii) For each type of coverage the date the individual's coverage terminates in accordance with the plan provisions of the succeeding carrier applicable to individual termination of coverage, such as termination of employment or ceasing to be an eligible dependent; or

(iii) In the case of a disabled individual for whom subsection 2 requires an extension of benefits, the end of any period of extension that is required of the prior

carrier by subsection 2 or, if the policy or contract of the prior carrier is not subject to that subsection, would have been required of that carrier had its policy or contract been subject to subsection 2 at the time the prior plan was discontinued and replaced by the plan of the succeeding carrier.

(3). When a preexisting conditions limitation is included in the plan of the succeeding carrier, the level of benefits applicable to preexisting conditions of persons joining the plan of the succeeding carrier in accordance with this subsection during the period of time this limitation applies under the new plan must be the lesser of:

(a) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(b) The benefits of the prior plan.

(4) When a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier must furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For purposes of this section, benefits of the prior plan are determined in accordance with the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.

4. Continuance of coverage in situations involving an individual moving from one group plan to another. This subsection indicates the liability of the succeeding carrier when an individual moves from one group plan to another. The liability applies whether or not the new group plan is through the same carrier. The liability does not apply to a dependent moving to a plan where the primary insured is already covered, or to an individual moving from coverage as a dependent to coverage as a primary insured.

A. A group hospital, medical or health care service contract issued for delivery in this State by a nonprofit hospital, medical or health service organization, other than a contract that provides benefits only for specific diseases or accidental injuries and that is medically underwritten or contains an exclusion for preexisting conditions, shall

waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior plan if the prior plan were still in effect. A "prior plan" is a plan in which the individual's coverage, under a contract issued in this State or a state that provides reciprocal protection to insureds previously covered by a plan issued in this State, terminated within 60 days prior to the effective date of the individual's coverage under the current plan.

B. The succeeding carrier is not required to duplicate any benefits covered by the prior carrier.

C. When a determination of the prior carrier's benefit is required by the succeeding carrier at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For purposes of this section, benefits of the prior plan are determined in accordance with the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.

D. For rating purposes, claims for preexisting conditions during the first 12 months of employment may not be charged directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. Any additional claims may be pooled among all such groups and subgroups. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

Sec. 2. 24-A MRSA §2804, sub-§3, as repealed and replaced by PL 1981, c. 147, §2, is amended to read:

3. An Except in the case of discontinuance and replacement of group health insurance in accordance with section 2809-B, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 3. 24-A MRSA §2805, sub-§3, as repealed and replaced by PL 1981, c. 147, §3, is amended to read:

3. An Except in the case of discontinuance and replacement of group health insurance in accordance with section 2809-B, an insurer may exclude or limit the coverage on any person as to

whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 4. 24-A MRSA §2805-A, sub-§4, as enacted by PL 1981, c. 147, §4, is amended to read"

4. ~~An~~ Except in the case of discontinuance and replacement of group health insurance in accordance with section 2809-B, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 5. 24-A MRSA §2806, sub-§3, as repealed and replaced by PL 1981, c. 147, §5, is amended to read:

3. ~~An~~ Except in the case of discontinuance and replacement of group health insurance in accordance with section 2809-B, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 6. 24-A MRSA §2807-A, sub-§3, as enacted by PL 1981, c. 147, §7, is amended to read:

3. ~~An~~ Except in the case of discontinuance and replacement of group health insurance in accordance with section 2809-B, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 7. 24-A MRSA §2808, sub-§4, as enacted by PL 1981, c. 147, §8, is amended to read:

4. ~~An~~ Except in the case of discontinuance and replacement of group health insurance in accordance with section 2809-B, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 8. 24-A MRSA §2809-B is enacted to read:

§2809-B. Discontinuance and replacement of group coverage

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Group" means any of the types of groups defined in sections 2804 to 2808.

B. "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

2. Extension of benefits. The following extension of benefits applies to coverage that is discontinued.

A. Every group contract, executed, delivered, issued for delivery, amended, continued or renewed on or after the effective date of this section, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group contract or of coverage for a subgroup within the contract as required by paragraphs B, C, D and E.

B. In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability has no effect on benefits payable for that disability or confinement.

C. In the case of hospital or medical expense coverages, other than dental expense, a reasonable extension of benefits provision is required. A provision is considered "reasonable" if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance.

D. Any applicable extension of benefits must be described in any contract or group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the contract. A premium may not be changed during the period of extension.

E. After discontinuance, the carrier remains liable only to the extent of its accrued liabilities and extensions of benefits.

3. Continuance of coverage in situations involving replacement of one carrier by another. This subsection indicates the carrier responsible for liability in those instances when the contract of one carrier replaces a health care benefit plan of another carrier for a group or subgroup.

A. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier is the same whether the group contract holder or other entity secures replacement coverage from a new carrier, self-insures or foregoes the provision of coverage.

B. The liability of the succeeding carrier is as follows.

(1) Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits shall be covered by that carrier's plan of benefits.

(2) Each person not covered under the plan of benefits of the succeeding carrier in accordance with subparagraph (1) shall be covered by the succeeding carrier in accordance with the following rules if the individual was covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class or classes of individuals eligible for coverage under the plan of the succeeding carrier. In the following provisions, any reference to a disabled individual is a reference to the status of the individual immediately prior to the date the coverage of the succeeding carrier becomes effective.

(a) The minimum level of benefits to be provided by the succeeding carrier is the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.

(b) Coverage must be provided by the succeeding carrier until the earliest of the following dates:

(i) The date the individual becomes eligible under the succeeding carrier's plan as described in subparagraph (1);

(ii) For each type of coverage, the date the individual's coverage terminates in accordance with the provisions of the succeeding carrier's plan applicable to individual termination of coverage, termination of employment or ceasing to be an eligible dependent; or

(iii) In the case of a disabled individual for whom subsection 2 requires an extension of benefits, the end of any period of extension that is required of the prior carrier by subsection 2 or, if the prior carrier's policy or contract is not subject to that subsection, would have been required of that carrier had its policy or contract been subject to subsection 2 at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

(3) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons who will be covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan must be the lesser of:

(a) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(b) The benefits of the prior plan.

(4) When a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier must furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For purposes of this section, benefits of the prior plan are determined in accordance with the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.

4. Continuance of coverage in situations involving an individual moving from one group plan to another. This subsection indicates the liability of the succeeding carrier for an individual who moves from one group plan to another. The liability applies whether or not the new group plan is with the same carrier. The liability does not apply to a dependent moving to a plan where the primary insured is already covered, or to an individual moving from coverage as a dependent to coverage as a primary insured.

A. A group policy that provides hospital, surgical or major medical expense insurance or any combination thereof, other than a contract that provides benefits for specific diseases or accidental injuries only and that is medically underwritten or contains an exclusion for preexisting conditions, shall include a waiver of any medical underwriting or preexisting conditions exclusion when those benefits would have been payable under a prior plan if the prior plan were still in effect. A "prior plan" is a plan in which the individual's coverage, under a contract issued in this State or a state that provides reciprocal protection to insureds previously covered by a plan issued in this State, terminated within 60 days prior to the effective date of the individual's coverage under the current plan.

B. The succeeding carrier is not required to duplicate any benefits covered by the prior carrier.

C. When a determination of the prior carrier's benefit is required by the succeeding carrier at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For purposes of this section, benefits of the prior plan are determined in accordance with the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.

D. For rating purposes, claims for preexisting conditions during the first 12 months of employment may not be charged directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. Any additional claims may be pooled among all such groups and subgroups. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

Sec. 9. 24-A MRSA §4210-A is enacted to read:

§4210-A. Discontinuance and replacement of group coverage

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Group" means any of the types of groups defined in sections 2804 to 2808.

B. "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

2. Extension of benefits. The following extension of benefits applies to coverage that is discontinued.

A. Every group contract executed, delivered, issued for delivery, amended, continued or renewed on or after the effective date of this section must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group contract or discontinuance of coverage for a subgroup in the contract as required by paragraphs B, C and D.

B. In the case of hospital or medical expense coverages, other than dental expense, a reasonable extension of benefits provision is required. A provision is considered "reasonable" if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance.

C. Any applicable extension of benefits must be described in any contract involved as well as in the evidence of coverage. The benefits payable during any period of extension may be subject to the regular benefit limits under the contract. A premium may not be charged during the period of extension.

D. After discontinuance, the health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits.

3. Continuance of coverage in situations involving replacement of one health maintenance organization by another. This subsection indicates the carrier responsible for liability in those instances when a contract of a health maintenance organization replaces a health care benefit plan of another carrier for a group or subgroup.

A. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier is the same whether the group contract holder or other entity secures replacement coverage from a new carrier, self-insures or foregoes the provision of coverage.

B. The liability of the succeeding carrier is as follows.

(1) Each person who is eligible for coverage in accordance with the succeeding health maintenance organization's plan of benefits is covered by that health maintenance organization's plan of benefits.

(2) Each person not covered under the plan of benefits of the succeeding health maintenance organization in accordance with subparagraph (1) shall be covered by the succeeding carrier in accordance with the following rules if the individual was covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class or classes of individuals eligible for coverage under the plan of the succeeding health maintenance organization. In the following provisions, any reference to a disabled individual is a reference to the individual's status immediately prior to the date

the succeeding health maintenance organization's coverage becomes effective.

(a) The minimum level of benefits to be provided by the succeeding health maintenance organization is the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.

(b) Coverage must be provided by the succeeding health maintenance organization until the earliest of the following dates:

(i) The date the individual becomes eligible under the succeeding health maintenance organization's plan as described in subparagraph (1);

(ii) For each type of coverage, the date the individual's coverage terminates in accordance with the provisions of the succeeding health maintenance organization's plan applicable to individual termination of coverage, termination of employment or ceasing to be an eligible dependent; or

(iii) In the case of a disabled individual for whom subsection 2 requires an extension of benefits, the end of any period of extension that is required of the prior carrier by subsection 2 or, if the prior carrier's policy or contract is not subject to that subsection, would have been required of that carrier had its policy or contract been subject to subsection 2 at the time the prior plan was discontinued and replaced by the succeeding health maintenance organization's plan.

(3) When a preexisting conditions limitation is included in the succeeding health maintenance organization's plan, the level of benefits applicable to preexisting conditions of persons who will be covered by the succeeding health maintenance organization's plan in accordance with this subsection during the period of time this limitation applies under the new plan must be the lesser of:

(a) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(b) The benefits of the prior plan.

(4) When a determination of the prior health maintenance organization's benefit is required by the succeeding health maintenance organization, at the succeeding health maintenance organization's request, the prior carrier must furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding health maintenance organization. For purposes of this section, benefits of the prior plan are determined in accordance with the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding health maintenance organization.

4. Continuance of coverage in situations involving an individual moving from one group plan to another. This subsection indicates the liability of the succeeding health maintenance organization for an individual who moves from one group plan to another. The liability applies whether or not the new group plan is with the same health maintenance organization. The liability does not apply to a dependent moving to a plan where the primary insured is already covered, or to an individual moving from coverage as a dependent to coverage as a primary insured.

A. A group contract issued by a health maintenance organization that is medically underwritten or contains an exclusion for preexisting conditions, shall include a waiver of any medical underwriting or preexisting conditions exclusion when those benefits would have been payable under a prior plan if the prior plan were still in effect. A "prior plan" is a plan in which the individual's coverage, under a contract issued in this State or a state that provides reciprocal protection to insureds previously covered by a plan issued in this State, terminated within 60 days prior to the effective date of the individual's coverage under the current plan.

B. The succeeding health maintenance organization is not required to duplicate any benefits covered by the prior carrier.

C. When a determination of the prior carrier's benefit is required by the succeeding health maintenance organization at the succeeding health maintenance organization's request, the prior carrier shall furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the

determination itself by the succeeding health maintenance organization. For purposes of this section, benefits of the prior plan are determined in accordance with the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding health maintenance organization.

D. For rating purposes, claims for preexisting conditions during the first 12 months of employment may not be charged directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. Any additional claims may be pooled among all such groups and subgroups. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

STATEMENT OF FACT

Gaps in insurance coverage could exist when persons change employment and when employers change insurers because employees are often required to satisfy a new preexisting condition exclusion or could be excluded from coverage entirely due to a medical condition. This bill requires group medical insurers and health maintenance organizations to waive medical underwriting and to waive the preexisting condition exclusion to the extent that benefits will have been covered under a prior group health plan which terminated within 60 days before the new coverage began. In the case of an employer changing insurers, the bill also provides for extension of coverage for insureds who are totally disabled.