

**Maine Revised Statute Title 24-A, Chapter 36:  
CONTINUITY OF HEALTH INSURANCE COVERAGE**

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## 24-A §2848. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1993, c. 349, §52 (RPR).]

**1. Evidence of individual insurability.** "Evidence of individual insurability" means medical information or other information that indicates health status, such as whether the individual is actively at work, used to determine whether coverage of an individual within the group is to be limited or excluded.

[ 1993, c. 349, §52 (RPR) .]

**1-A. COBRA continuation provision.** "COBRA continuation provision" means any of the following:

A. Section 4980B of the Internal Revenue Code of 1986, other than Subsection (f)(1) as it relates to pediatric vaccines; [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

B. Part 6 of Subtitle B of Title I of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1161, other than Section 609; or [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

C. Title XXII of the federal Public Health Service Act, 42 United States Code, Section 201. [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

[ 1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF) .]

**1-B. Federally creditable coverage.** "Federally creditable coverage" is defined as follows.

A. "Federally creditable coverage" means health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier;

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act or a state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e). [1999, c. 256, Pt. L, §2 (AMD).]

B. "Federally creditable coverage" does not include coverage consisting solely of one or more of the following:

- (1) Coverage for accident or disability income insurance or any combination of those coverages;
- (2) Liability insurance, including general liability insurance and automobile liability insurance;
- (3) Coverage issued as a supplement to liability insurance;
- (4) Workers' compensation or similar insurance;
- (5) Automobile medical payment insurance;
- (6) Credit insurance;
- (7) Coverage for on-site medical clinics; or
- (8) Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits. [1999, c. 256, Pt. L, §2 (AMD).]

C. "Federally creditable coverage" does not include the following benefits if those benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

- (1) Limited scope dental or vision benefits;
- (2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and
- (3) Other similar, limited benefits as specified in federal regulations issued pursuant to Public Law 104-191. [1999, c. 256, Pt. L, §2 (AMD).]

D. "Federally creditable coverage" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, and if no coordination exists between the provision of the benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and those benefits are paid for an event without regard to whether benefits are provided for that event under a group health plan maintained by the same plan sponsor:

- (1) Coverage only for a specified disease or illness; and
- (2) Hospital indemnity or other fixed indemnity insurance. [1999, c. 256, Pt. L, §2 (AMD).]

E. "Federally creditable coverage" does not include the following if it is offered as a separate policy, certificate or contract of insurance:

- (1) Medicare supplemental health insurance under the Social Security Act, Section 1882(g)(1);
- (2) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55; and
- (3) Similar supplemental coverage under a group health plan. [1999, c. 256, Pt. L, §2 (AMD).]

For purposes of this subsection, a "period of continuing federally creditable coverage" means a period in which an individual has maintained federally creditable coverage through one or more plans or programs, with no break in coverage exceeding 63 days. In calculating the aggregate length of a period of continuing federally creditable coverage that includes one or more breaks in coverage, only the time actually covered is counted. A waiting period is not counted as a break in coverage, but is not counted as a period of actual coverage unless the individual has other federally creditable coverage during this period. For purposes of this subsection and subsection 1-C, "group health plan" has the same meaning as specified in the federal Public Health Service Act, Title XXVII, Section 2791(a).

[ 2005, c. 121, Pt. H, §1 (AMD) . ]

**1-C. Federally eligible individual.** "Federally eligible individual" means an individual:

A. Who has had a period of continuing federally creditable coverage, as defined in subsection 1-B, ending not more than 63 days before applying for an individual health plan, with an aggregate length of federally creditable coverage, as defined in subsection 1-B, of at least 18 months; [1999, c. 256, Pt. L, §3 (AMD).]

B. Whose most recent prior federally creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan; [1999, c. 256, Pt. L, §3 (AMD).]

C. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, Medicare, or a state plan under Title XIX, Medicaid or any successor program and who does not have other health insurance coverage; [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

D. Whose most recent federally creditable coverage was not terminated based on nonpayment of premiums, fraud or intentional misrepresentation of material fact; and [1999, c. 256, Pt. L, §3 (AMD).]

E. Who, if offered the option of continuation of coverage under a COBRA continuation provision, as defined by subsection 1-A, or under a similar state program, elected continuation of coverage and has exhausted that coverage. For purposes of this paragraph, an individual is considered to have exhausted COBRA continuation coverage when the individual no longer resides, lives or works in a service area of a managed care plan and there is no other COBRA continuation coverage available to the individual. [2001, c. 258, Pt. D, §2 (AMD).]

[ 2001, c. 258, Pt. D, §2 (AMD) .]

**1-D. Governmental plan.** "Governmental plan" has the meaning given under Section 3(32) of the federal Employee Retirement Income Security Act of 1974 or any federal governmental employee plan.

[ 1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF) .]

**2. Group.** "Group" means any of the types of groups under sections 2804 to 2808.

[ 1993, c. 349, §52 (RPR) .]

**2-A. Medical care.** Medical care includes the amounts paid for:

A. The diagnosis, care, mitigation, treatment or prevention of disease, or the amounts paid for the purpose of affecting a structure or function of the body; [1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF).]

B. Transportation primarily for, and essential to, medical care under paragraph A; and [1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF).]

C. Insurance coverage for medical care under paragraphs A and B. [1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF).]

[ 1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF) .]

**3. Preexisting condition exclusion.**

[ 1997, c. 445, §32 (AFF); 1997, c. 445, §22 (RP) .]

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

[ 1993, c. 349, §52 (RPR) . ]

**5. Waiting period.** "Waiting period" means a period of time after the date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.

[ 1999, c. 256, Pt. L, §4 (AMD) . ]

#### SECTION HISTORY

1989, c. 767, §4 (NEW). 1989, c. 801, §3 (NEW). 1989, c. 867, §§8,10 (NEW). 1991, c. 695, §6 (RPR). 1991, c. 824, §A52 (RPR). 1993, c. 349, §52 (RPR). 1997, c. 445, §§20-22 (AMD). 1997, c. 683, §A13 (AMD). 1997, c. 777, §B4 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 256, §§L2-4 (AMD). 2001, c. 258, §§D2,E5 (AMD). 2005, c. 121, §H1 (AMD).

## 24-A §2848-A. APPLICABILITY TO CERTAIN SELF-INSURED EMPLOYERS

For purposes of this chapter, an uninsured employee health plan that covers employees working in this State, including the uninsured portion of a partially insured employee health plan, is considered a group medical insurance policy and the employer maintaining the plan is considered an insurer, if the plan is subject to state regulation by virtue of the governmental plan or nonelecting church plan exception to the federal definition of "employee benefit plan" in the federal Employee Retirement Income Security Act, 29 United States Code, Section 1003(b). [1997, c. 445, §23 (NEW); 1997, c. 445, §32 (AFF).]

#### SECTION HISTORY

1997, c. 445, §23 (NEW). 1997, c. 445, §32 (AFF).

## 24-A §2849. CONTINUITY ON REPLACEMENT OF GROUP POLICY

**1. Policies subject to this section.** Notwithstanding any other provision of law, this section applies to all group and blanket medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by a nonprofit hospital or medical service organization, insurer or health maintenance organization, or to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the policyholder has applied for coverage under the replacement policy within 90 days after termination of coverage under the contract or policy being replaced. For purposes of this section, the group or blanket policy issued to replace the prior contract or policy is the "replacement policy." The group or blanket contract or policy or uninsured employee benefit plan, or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

[ 2007, c. 199, Pt. D, §1 (AMD) . ]

**2. Persons provided continuity of coverage under this section.** This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.

[ 1993, c. 349, §53 (RPR) . ]

**3. Prohibition against discontinuity.** In a replacement policy subject to this section, an insurer or health maintenance organization may not, for any person described in subsection 2:

A. Request that the person provide or otherwise seek to obtain evidence of individual insurability. This in no way limits the insurer's right to require information concerning the health of the individuals in the group to determine whether the group as a whole is insurable or to determine rates for the group as a whole; [1993, c. 349, §53 (RPR).]

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; [1997, c. 370, Pt. B, §2 (AMD).]

C. Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section; or [2009, c. 244, Pt. E, §2 (AMD).]

D. Direct or propose to the employer or the person that the person purchase an individual plan in lieu of providing coverage under the replacement policy. The superintendent shall initiate enforcement proceedings when investigation of the circumstances surrounding procurement of an individual policy at the time of replacement of the group policy produces evidence that such procurement was undertaken in violation of this section and section 2155-A. [1997, c. 370, Pt. B, §3 (NEW).]

[ 2009, c. 244, Pt. E, §2 (AMD) .]

**3-A. Persons subject to a preexisting condition exclusion.** Notwithstanding subsection 3, paragraph C, an insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the replaced contract or policy. The preexisting condition exclusion period under the replacement policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the replaced contract or policy.

[ 2009, c. 244, Pt. E, §3 (NEW) .]

#### **4. Persons covered for fewer than 90 continuous days.**

[ 2001, c. 258, Pt. E, §6 (RP) .]

**5. Liability after discontinuance.** The nonprofit hospital or medical service organization, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.

[ 1993, c. 349, §53 (RPR) .]

**6. Rules.** The superintendent may adopt rules that substitute for the requirement of subsection 3, paragraph C a requirement that prohibits application of a preexisting condition exclusion or waiting period with respect to classes or categories of benefits that are covered under the replaced contract or policy. The rules must define those classes or categories consistent with any federal regulations adopted pursuant to the federal Public Health Service Act, Title XXVII, Section 2701(c)(3)(B).

[ 1997, c. 445, §24 (NEW); 1997, c. 445, §32 (AFF) .]

#### SECTION HISTORY

1989, c. 835, §3 (NEW). 1989, c. 867, §§8,10 (NEW). 1991, c. 695, §7 (RPR). 1991, c. 824, §A53 (RPR). 1993, c. 666, §D3 (AMD). 1993, c. 349, §53 (RPR). 1995, c. 332, §F3 (AMD). 1997, c. 370, §§B2,3 (AMD). 1997, c. 445, §24 (AMD). 1997, c. 445, §32 (AFF). 2001, c. 258, §E6 (AMD). 2007, c. 199, Pt. D, §1 (AMD). 2009, c. 244, Pt. E, §§2, 3 (AMD).

## 24-A §2849-A. EXTENSION OF BENEFITS FOR DISABLED PERSONS

**1. Policies subject to this section.** This section applies to group and blanket policies that provide hospital or medical expense coverage or specific indemnity during hospital confinement. This section does not apply to group policies providing coverage only for dental expense or to group long-term care policies as defined in section 5051 or group short-term and long-term disability policies.

[ 1999, c. 256, Pt. L, §5 (AMD) .]

**2. Requirement.** Every group or blanket policy subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group or blanket policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A premium may not be charged during the period of extension. For a policy providing hospital or medical expense coverage, an extension of benefits provision is 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. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement.

[ 2007, c. 199, Pt. D, §2 (AMD) .]

**3. Description of benefit extension.** The extension of benefits provision must be described in all policies and group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the policy.

[ 1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

**4. Liability after discontinuance.** After discontinuance of a policy, the insurer or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits.

[ 1997, c. 604, Pt. H, §1 (AMD) .]

**4-A. Coordination of benefits.** If replacement coverage is secured by the group or blanket policyholder from an insurer, nonprofit hospital or medical service organization or health maintenance organization and a totally disabled person is covered under the replacement coverage, the replacement coverage must pay as primary coverage and the replaced coverage must pay as secondary coverage for the covered expenses directly relating to the condition causing total disability during the extension of benefits required under this section.

[ 2007, c. 199, Pt. D, §3 (AMD) .]

**5. Rules.** The superintendent shall adopt rules to define the term "total disability" for purposes of this section. The definition must identify persons who are unable, as a result of disability, to obtain comparable alternative coverage through comparable employment or otherwise.

[ 1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

### SECTION HISTORY

1989, c. 867, §§8,10 (NEW). 1991, c. 695, §8 (AMD). 1997, c. 604, §§1,2 (AMD). 1999, c. 256, §§L5,6 (AMD). 2007, c. 199, Pt. D, §§2, 3 (AMD).

## 24-A §2849-B. CONTINUITY FOR INDIVIDUAL WHO CHANGES GROUPS

**1. Policies subject to this section.** This section applies to all individual, group and blanket medical insurance policies except hospital indemnity, specified accident, specified disease, long-term care and short-term policies issued by insurers or health maintenance organizations. For purposes of this section, a short-term policy is an individual, nonrenewable policy issued for a term that does not exceed 12 months. This section does not apply to Medicare supplement policies as defined in section 5001, subsection 4.

[ 1999, c. 36, §1 (AMD) .]

**2. Persons provided continuity of coverage.** Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual , group or blanket insurance policy or health maintenance organization policy if:

A. That person was covered under an individual , group or blanket contract or policy issued by a nonprofit hospital or medical service organization, insurer, health maintenance organization or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program, including, but not limited to, those listed in section 2848, subsection 1-B, paragraph A, subparagraphs (3) to (10). For purposes of this section, the individual , group or blanket policy under which the person is seeking coverage is the "succeeding policy." The group, blanket or individual contract or policy, uninsured employee benefit plan or governmental program that previously covered the person is the "prior contract or policy"; and [ 2007, c. 199, Pt. D, §4 (AMD) .]

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 90 days before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for a health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section. [ 2007, c. 199, Pt. D, §4 (AMD) .]

C. [1997, c. 445, §32 (AFF); 1997, c. 445, §25 (RP) .]

D. [1999, c. 36, §3 (RP) .]

This section does not apply to replacements of group or blanket coverage within the scope of section 2849 or if the succeeding policy is an individual policy and the prior contract or policy was a short-term policy.

[ 2007, c. 199, Pt. D, §4 (AMD) .]

**3. Exception for late enrollees.** Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee except as provided in this subsection. A late enrollee may be excluded from coverage for a waiting period of not more than 12 months based on medical underwriting or preexisting conditions. If a shorter waiting period or no waiting period is imposed, coverage for the late enrollee may exclude preexisting conditions for the lesser of 18 months, reduced by any federally creditable coverage, or 12 months. The exclusion is subject to the limitations set forth in section 2850. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy or terminated coverage under the succeeding contract because that individual was covered under a prior contract or policy and:

(1) Coverage under that contract or policy ceased because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce; or

(2) Employer contributions toward that coverage were terminated; [1997, c. 445, §32 (AFF); 1997, c. 445, §26 (RPR).]

A-1. That person incurs a claim under a prior contract or policy that would meet or exceed that contract or policy's lifetime limit on all benefits, and a request for enrollment is made not later than 30 days after a claim is denied in whole or in part due to the operation of a lifetime limit on all benefits. [2007, c. 199, Pt. A, §4 (NEW).]

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order; [1995, c. 332, Pt. F, §5 (AMD).]

C. [1997, c. 777, Pt. B, §5 (RP).]

C-1. That person was covered by the Cub Care program under Title 22, section 3174-T, and the request for replacement coverage is made while coverage is in effect or within 30 days from the termination of coverage; or [2005, c. 683, Pt. A, §42 (AMD).]

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible. [1995, c. 332, Pt. F, §5 (NEW).]

[ 2007, c. 199, Pt. A, §4 (AMD) .]

**3-A. Prohibition against discontinuity in group policies.** Except as provided in this section, in a group policy subject to this section, the insurer or health maintenance organization shall, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

[ 2009, c. 244, Pt. E, §4 (NEW) .]

**3-B. Persons subject to a preexisting condition exclusion.** Notwithstanding subsection 3-A, an insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the prior contract or policy. The preexisting condition exclusion period under the succeeding policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the prior contract or policy.

[ 2009, c. 244, Pt. E, §5 (NEW) .]

**4. Prohibition against discontinuity in individual and blanket policies.** Except as provided in this section, in an individual or blanket policy subject to this section, the insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect or to the extent that benefits would have been payable under the prior contract or policy if not for the operation of a lifetime limit on all benefits. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

[ 2009, c. 244, Pt. E, §6 (AMD) .]

**4-A. Alternative method.** The superintendent may adopt rules that substitute for the requirement of subsection 4 a requirement that prohibits application of a medical underwriting or preexisting condition exclusion with respect to classes or categories of benefits that are covered under the replaced contract or policy. The rules must define those classes or categories consistent with any federal regulations adopted pursuant to the federal Public Health Service Act, Title XXVII, Section 2701(c)(3)(B).

[ 1997, c. 445, §27 (NEW); 1997, c. 445, §32 (AFF) .]

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

[ 1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

**6. Limit on premium increase.** For rating purposes, an insurer or health maintenance organization may not charge claims for preexisting conditions of any person subject to this section, during the first 12 months of employment of that person, 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. The insurer or health maintenance organization may pool any additional claims among all such groups and subgroups covered by that insurer or health maintenance organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

[ 1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

**7. Reinsurance, excess insurance or administrative services.** An insurer may only offer, issue or renew reinsurance or excess insurance coverage or offer administrative services to an uninsured employee benefit plan that provides payment for health services received by employees and their dependents when that plan for the payment of health services and reinsurance and excess insurance coverage meets the requirements of continuity of coverage in this chapter.

[ 1993, Pt. A, §14 (NEW); 1993, Pt. F, §1 (NEW) .]

**8. Short-term insurance.** A person eligible for continuity of coverage under subsection 2 may be allowed to purchase coverage under an individual, nonrenewable short-term policy. The issuance of a short-term policy is subject to the following conditions.

A. Upon offering an individual short-term policy for purchase, an insurer or the insurer's agent or broker must provide written disclosure of the terms and benefits of the policy. Specific disclosure that the short-term policy is not subject to any limitation on preexisting condition exclusions or the provisions of guaranteed renewal and continuity of coverage is required. [1995, c. 342, §8 (NEW) .]

B. An insurer or the insurer's agent or broker may not issue a short-term policy that replaces a prior short-term policy if the combined term of the new policy and all prior successive policies exceed 12 months. All individuals making an application for coverage under a short-term policy must disclose any prior coverage under a short-term policy and the policy duration. [1995, c. 342, §8 (NEW) .]

[ 1995, c. 342, §8 (NEW) .]

#### SECTION HISTORY

1989, c. 867, §§8,10 (NEW). 1991, c. 695, §§9,10 (AMD). 1993, c. 477, §§A8-14 (AMD). 1993, c. 666, §D4 (AMD). 1993, c. 477, §F1 (AFF). 1995, c. 77, §2 (AMD). 1995, c. 332, §§F4,5 (AMD). 1995, c. 342, §§6-8 (AMD).

1995, c. 625, §B10 (AMD). 1995, c. 673, §B3 (AMD). 1997, c. 370, §C4 (AMD). 1997, c. 445, §§25-27 (AMD). 1997, c. 777, §§B5,6 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 36, §§1-3 (AMD). 1999, c. 256, §L7 (AMD). 2001, c. 258, §§E7,8 (AMD). 2005, c. 683, §A42 (AMD). 2007, c. 199, Pt. A, §§4, 5 (AMD). 2007, c. 199, Pt. D, §4 (AMD). 2009, c. 244, Pt. E, §§4-6 (AMD).

## 24-A §2849-C. CERTIFICATIONS OF COVERAGE

**1. Application.** This section applies to:

A. Individual health plans subject to section 2736-C; and [2001, c. 258, Pt. C, §1 (NEW).]

B. Group and blanket health insurance contracts subject to chapter 35, except:

(1) Medicare supplement policies subject to chapter 67; and

(2) Contracts designed to cover specific diseases, hospital indemnity or accidental injury only. [2001, c. 258, Pt. C, §1 (NEW).]

[2001, c. 258, Pt. C, §1 (NEW).]

**2. Requirement for certification of period of creditable coverage.** The requirement for a certification of the period of creditable coverage is as follows.

A. A carrier, as defined in section 4301-A, subsection 3, must provide the certification described in paragraph B with respect to health plans subject to this section:

(1) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) On the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in subparagraph (1) or (2), whichever is later. The certification under subparagraph (1) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision. [2001, c. 258, Pt. C, §1 (NEW).]

B. The certification described in this paragraph is a written certification of:

(1) The period of federally creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision;

(2) The waiting period, if any, imposed with respect to the individual for any coverage under the plan; and

(3) An educational statement regarding the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, consistent with federal law. [2007, c. 199, Pt. A, §6 (AMD).]

[2007, c. 199, Pt. A, §6 (AMD).]

**3. Alternative evidence of prior coverage.** A carrier may not deny continuity rights as required by section 2849-B solely because the individual does not provide a certification described in subsection 2. The carrier must accept alternative evidence of prior coverage provided by the individual. If the individual asserts the existence of prior coverage but is unable to provide evidence, the carrier must make reasonable efforts to

verify the existence of the prior coverage. The carrier may deny continuity rights if the individual refuses to cooperate in the carrier's efforts to verify prior coverage, such as if the individual refuses to provide needed authorization for the release of information to the carrier when requested by the carrier.

[ 2001, c. 258, Pt. C, §1 (NEW) .]

**4. Notice.** A carrier may not impose a preexisting condition exclusion before providing the individual with notice consistent with federal law of the individual's continuity rights and giving the individual an opportunity to provide a certification as described in subsection 2 or alternative evidence of prior coverage as described in subsection 3.

[ 2007, c. 199, Pt. A, §7 (AMD) .]

**5. Rules.** The superintendent may issue rules specifying the contents of certifications or other requirements consistent with this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[ 2001, c. 258, Pt. C, §1 (NEW) .]

#### SECTION HISTORY

2001, c. 258, §C1 (NEW). 2007, c. 199, Pt. A, §§6, 7 (AMD).

## 24-A §2850. LIMITATIONS ON EXCLUSION AND WAITING PERIODS

**1. Application.** This section applies to individual, group and blanket medical insurance contracts subject to chapters 33 and 35, except Medicare supplement contracts, converted contracts issued under section 2809-A and contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

[ 1999, c. 256, Pt. L, §8 (AMD) .]

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

A. "Date of enrollment" means the effective date of coverage or, if earlier, the first day of the waiting period for such coverage. [2001, c. 258, Pt. E, §9 (NEW).]

B. "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. [2001, c. 258, Pt. E, §9 (NEW).]

[ 2001, c. 258, Pt. E, §9 (RPR) .]

**2. Limitation.** An individual, group or blanket contract issued by an insurer may not impose a preexisting condition exclusion except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months from the date of enrollment, including the waiting period, if any. For purposes of this subsection, "waiting period" includes any period between the time a substantially complete application for an individual or small group health plan is filed and the time the coverage takes effect. A preexisting condition exclusion may not be more restrictive than as follows.

A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period ending on the earlier of the date of enrollment in the contract and the date of enrollment in a prior contract covering

the same group if there has not been a gap in coverage of greater than 90 days between contracts. An exclusion may not be imposed relating to pregnancy as a preexisting condition. [2009, c. 244, Pt. E, §7 (AMD).]

B. In an individual contract not subject to paragraph C, or in a blanket policy, a preexisting condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the date of application or to a pregnancy existing on the effective date of coverage. [1999, c. 256, Pt. L, §9 (AMD).]

C. An individual policy issued on or after January 1, 1998 to a federally eligible individual as defined in section 2848 may not contain a preexisting condition exclusion. [1997, c. 445, §29 (NEW); 1997, c. 445, §32 (AFF).]

D. A routine preventive screening or test yielding only negative results may not be considered to be diagnosis, care or treatment for the purposes of this subsection. [1999, c. 256, Pt. L, §9 (AMD).]

E. Genetic information may not be used as the basis for imposing a preexisting condition exclusion in the absence of a diagnosis of the condition relating to that information. For the purposes of this paragraph, "genetic information" has the same meaning as set forth in the Code of Federal Regulations. [1997, c. 445, §29 (NEW); 1997, c. 445, §32 (AFF).]

[ 2009, c. 244, Pt. E, §7 (AMD) .]

#### SECTION HISTORY

1989, c. 867, §§8,10 (NEW). 1991, c. 695, §11 (AMD). 1993, c. 477, §A15 (AMD). 1993, c. 547, §4 (AMD). 1993, c. 477, §F1 (AFF). 1997, c. 370, §C5 (AMD). 1997, c. 445, §§28,29 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 256, §§L8,9 (AMD). 2001, c. 258, §§D3,E9 (AMD). 2007, c. 199, Pt. A, §8 (AMD). 2009, c. 244, Pt. E, §7 (AMD).

## 24-A §2850-A. GYNECOLOGICAL AND OBSTETRICAL SERVICES

*(REALLOCATED TO TITLE 24-A, SECTION 2847-F)*

#### SECTION HISTORY

1995, c. 617, §4 (NEW). 1995, c. 617, §6 (AFF). 1997, c. 370, §H1 (RAL).

## 24-A §2850-B. GUARANTEED RENEWAL; CESSATION OF BUSINESS

**1. Application.** This section applies to:

A. Individual health plans subject to section 2736-C; and [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

B. Group and blanket medical insurance contracts subject to chapter 35 except:

(1) Medicare supplement policies subject to chapter 67; and

(2) Contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

[1999, c. 256, Pt. L, §10 (AMD).]

[ 1999, c. 256, Pt. L, §10 (AMD) .]

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

A. "Carrier" means an insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue group health plans in this State. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

B. "Individual market" means individual or group policies or contracts subject to section 2736-C. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

C. "Large group market" means groups not subject to section 2736-C or 2808-B. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

D. "Small group market" means groups subject to section 2808-B. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

[ 1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

**3. Renewal.** Coverage may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

A. When the policyholder or contract holder fails to pay premiums or contributions in accordance with the terms of the contract or the carrier has not received timely premium payments; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

B. For fraud or intentional misrepresentation of material fact by the policyholder or contract holder; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

C. With respect to coverage of individuals under a group policy or contract, for fraud or intentional misrepresentation of material fact on the part of the individual or the individual's representative; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

D. In the large or small group market, for noncompliance with the carrier's minimum participation requirements, which may not exceed the participation requirement when the policy was issued; [2007, c. 199, Pt. C, §1 (AMD).]

E. With respect to a managed care plan, as defined in section 4301-A, if there is no longer an insured who lives, resides or works in the service area; [2001, c. 1, §34 (COR).]

F. When the carrier ceases offering large or small group health plans in compliance with subsection 4 and does not renew any existing policies in that market; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

F-1. When the carrier ceases offering individual health plans in compliance with section 2736-C, subsection 4 and does not renew any existing policies in that market; [2007, c. 199, Pt. C, §2 (NEW).]

G. When the carrier ceases offering a product and meets the following requirements:

(1) In the large group market:

(a) The carrier must provide notice to the policyholder and to the insureds at least 90 days before termination;

(b) The carrier must offer to each policyholder the option to purchase any other product currently being offered in the large group market; and

(c) In exercising the option to discontinue the product and in offering the option of coverage under division (b), the carrier must act uniformly without regard to the claims experience of the policyholders or the health status of the insureds or prospective insureds;

(2) In the small group market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2808-B;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and to the insureds at least 90 days before replacement; or

(3) In the individual market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and, if a group policy, to the insureds at least 90 days before replacement; [ 2003, c. 428, Pt. A, §1 (AMD). ]

H. In renewing a large group policy in accordance with this section, a carrier may modify the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications are applied uniformly to all policyholders of the same product; or [ 2003, c. 428, Pt. A, §1 (AMD). ]

I. In renewing an individual or small group policy in accordance with this section, a carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Modifications not meeting the requirements in this paragraph are considered a discontinuance of the product pursuant to paragraph G.

(1) A modification pursuant to this paragraph must be approved by the superintendent. The superintendent shall approve the modification if it meets the requirements of this section.

(2) A change in a requirement for eligibility is not a minor modification pursuant to this paragraph if the change results in the exclusion of a class or category of enrollees currently covered.

(3) Benefit modifications required by law are deemed minor modifications for purposes of this paragraph.

(4) Benefit modifications other than modifications required by law are minor modifications only if they meet the requirements of this subparagraph. For purposes of this subparagraph, changes in conditions or requirements specified in the policy, such as preauthorization requirements, are considered benefit modifications.

(a) The total of any increases in benefits may not increase the actuarial value of the total benefit package by more than 5%.

(b) The total of any decreases in benefits may not decrease the actuarial value of the total benefit package by more than 5%.

(c) For purposes of the calculations in divisions (a) and (b), increases and decreases must be considered separately and may not offset one another.

(5) A carrier must give 60 days' notice of any modification pursuant to this paragraph to all affected policyholders and certificate holders. [ 2003, c. 428, Pt. A, §2 (NEW). ]

[ 2007, c. 199, Pt. C, §§1, 2 (AMD). ]

**4. Cessation of business.** Carriers that provide health plans in the large group or small group markets after the effective date of this section that plan to cease offering coverage in one or both of those markets must comply with the following requirements.

A. Notice of the decision to cease business in that market must be provided to the bureau 3 months before the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the bureau and to the policyholder or contract holder 6 months before nonrenewal. [2001, c. 258, Pt. B, §3 (AMD).]

B. Carriers that cease to write new small group business continue to be governed by section 2808-B with respect to small group contracts in force and their renewal or replacement contracts. [2001, c. 258, Pt. E, §11 (AMD).]

C. Carriers that cease to write new business in that market are prohibited from writing new business in that market for a period of 5 years after the date of termination of the last policy unless the superintendent waives this requirement for good cause shown. [2001, c. 258, Pt. B, §3 (AMD).]

[ 2001, c. 258, Pt. B, §3 (AMD); 2001, c. 258, Pt. E, §11 (AMD) .]

**5. Association plans.** The requirements of this subsection apply to group contracts that are subject to this section and that are issued to association groups pursuant to section 2805-A. Carriers shall renew coverage for association members if coverage through an association is terminated because the association ceases to exist, changes its membership eligibility criteria, fails to pay premiums, commits fraud or misrepresentation or voluntarily terminates the group policy.

A. If coverage to an employer through an association is terminated, the carrier shall renew the coverage with the employer becoming the policyholder. [2005, c. 121, Pt. G, §1 (NEW).]

B. If coverage to an individual member of an association is terminated, the carrier shall renew the coverage with the individual becoming the policyholder. A carrier that has been granted an exemption pursuant to section 2736-C, subsection 9 does not lose that exemption simply by virtue of renewing coverage to individuals under this paragraph. [2005, c. 121, Pt. G, §1 (NEW).]

The requirements of this subsection do not apply if the employer or individual fails to pay premiums, commits fraud or misrepresentation, voluntarily terminates membership in the association or ceases to qualify for membership for reasons other than a change in the association's membership eligibility criteria.

[ 2005, c. 121, Pt. G, §1 (NEW) .]

#### SECTION HISTORY

1997, c. 445, §30 (NEW). 1997, c. 445, §32 (AFF). 1999, c. 256, §L10 (AMD). 2001, c. 258, §§E10,11 (AMD). 2001, c. 258, §B3 (AMD). RR 2001, c. 1, §34 (COR). 2003, c. 428, §§A1,2 (AMD). 2005, c. 121, §G1 (AMD). 2007, c. 199, Pt. C, §§1, 2 (AMD).

## 24-A §2850-C. NONDISCRIMINATION

**1. Application.** This section applies to group medical insurance contracts subject to chapter 35 other than contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

[ 1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

**2. Eligibility and premium contributions.** A carrier may not establish rules for eligibility of an individual to enroll, or require an individual to pay a premium or contribution that is greater than that for a similarly situated individual, based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability in relation to the individual or a dependent of the individual. Nothing in this section requires a group health plan to provide particular benefits other than those provided under the terms of the plan or restricts the amount an employer may be charged for coverage. Nothing in this section prohibits establishing limitations or restrictions on the

amount, level, extent or nature of the benefits for similarly situated individuals enrolled in the plan. Nothing in this section prohibits a carrier from establishing premium discounts or refunds or modifying applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

[ 1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

SECTION HISTORY

1997, c. 445, §30 (NEW). 1997, c. 445, §32 (AFF).

## 24-A §2850-D. RULES

Rules adopted pursuant to this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

SECTION HISTORY

1997, c. 445, §30 (NEW). 1997, c. 445, §32 (AFF).

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