

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

Table of Contents

Section 1.	Authority
Section 2.	Scope
Section 3.	Definitions
Section 4.	Effective Date of Discontinuance for Non-Payment of Premium or Subscription Charges
Section 5.	Requirements for Notice of Discontinuance
Section 6.	Extension of Benefits
Section 7.	Continuance of Coverage in Situations Involving Replacement of One Carrier by Another
Section 8.	Effective Date

Section 1. Authority

This regulation is adopted by [title of supervisory authority] pursuant to Section [insert applicable section] of the [insert state] Insurance Code.

Section 2. Scope

This regulation is applicable to all insurance policies and subscriber contracts issued or provided by a carrier on a group or group-type basis covering persons as employees of employers or as members of unions or associations.

Section 3. Definitions

For purposes of this Act:

- A. (1) “Carrier” means a person or an entity that offers or provides a policy, contract or certificate of insurance coverage in this state.
- (2) “Carrier” includes an insurer, a health maintenance organization, a nonprofit service corporation or any other person or entity providing a policy, contract or certificate of insurance coverage subject to state insurance regulation.
- B. “Group-type basis” means a benefit plan, other than a “salary budget” plan utilizing individual insurance policies or subscriber contracts, which meets the following conditions:
 - (1) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;
 - (2) The coverage is not available to the general public and can be obtained and maintained only because of the covered person’s membership in or connection with the particular organization or group;
 - (3) There are arrangements for bulk payment of premiums or subscription charges to the carrier; and

Discontinuance and Replacement Regulation

- (4) There is sponsorship of the plan by the employer, union or association.
- C.
- (1) “Health insurance coverage” means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.
 - (2) “Health insurance coverage” shall not include one or more, or any combination of, the following:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub.L.No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.
 - (3) “Health insurance coverage” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:
 - (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.
 - (4) “Health insurance coverage” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) “Health insurance coverage” shall not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.

Section 4. Effective Date of Discontinuance for Non-Payment of Premium or Subscription Charges

- A. If a policy or contract subject to this regulation provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.
- B. If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled workday after the date upon which the notice is delivered.

Section 5. Requirements for Notice of Discontinuance

- A. A notice of discontinuance given by the carrier shall include a request to the group policyholder or other entity involved to notify employees covered under the policy or subscriber contract of the date as of which the group policy, contract or certificate will discontinue and to advise that, unless otherwise provided in the policy, contract or certificate the carrier shall not be liable for claims for losses incurred after the date of discontinuance. The notice of discontinuance also shall advise, in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.
- B. The carrier shall prepare and furnish to the policyholder or other entity at the same time it gives a notice of discontinuance a supply of notice forms to be distributed to the employees or members concerned, indicating the discontinuance and the effective date of the discontinuance, and urging the employees or members to refer to their certificates or contracts in order to determine what rights, if any, are available to them upon the discontinuance.

Section 6. Extension of Benefits

- A. Every group policy, contract or certificate subject to this regulation issued on or after the effective date of this regulation, or under which the level of benefits is altered, modified or amended on or after the effective date of this regulation, shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy, contract or certificate as required by the following subsections of this section.
- B. In the case of a group life plan that contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group policy, contract or certificate shall not operate to terminate the extension.
- C. In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the group policy, contract or certificate during a disability shall have no effect on benefits payable for that disability or confinement.
- D.
 - (1) In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required.
 - (2) An extension of benefits or accrued liability provision will be considered “reasonable” if:
 - (a) It provides an extension of at least twelve (12) months under “major medical” and “comprehensive medical” type coverages; and
 - (b) Under other types of hospital or medical expense coverages, it provides:
 - (i) An extension of benefits of at least ninety (90) days; or
 - (ii) An accrued liability for expenses incurred during a period of disability or during a period of at least ninety (90) days starting with a specific event that occurred while coverage was in force (e.g., an accident).
- E.
 - (1) An applicable extension of benefits or accrued liability shall be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension of benefits or accrued liability may be subject to the policy’s, contract’s or certificate’s regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.
 - (2) For hospital or medical expense coverages, the benefit payments may be limited to payments applicable to the disabling condition only.

Section 7. Continuance of Coverage in Situations Involving Replacement of One Carrier by Another

- A. This section shall indicate the carrier responsible for liability in those instances in which one carrier's (succeeding carrier) policy, contract or certificate replaces a plan of similar benefits of another (prior carrier).
- B. After discontinuance of the policy, contract or certificate, the prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.
- C. (1) (a) If the individual was validly covered under the prior plan on the date of discontinuance, each individual who is eligible for coverage in accordance with the succeeding carrier's plan of benefits with respect to the class or classes of individuals eligible for coverage under the succeeding carrier's plan and any actively-at-work and nonconfinement rules and requests enrollment shall be enrolled and covered by the succeeding carrier's plan of benefits.
 - (b) In the case of health insurance coverage:
 - (i) A succeeding carrier shall not have any nonconfinement rules in its plan of benefits; and
 - (ii) Any actively-at-work rules provided in the succeeding carrier's plan of benefits shall provide that absence from work due to any health status-related factor be treated as being actively-at-work.
 - (c) For purposes of this paragraph, "health status-related factor" means any of the following factors:
 - (i) Health status;
 - (ii) Medical condition, including both physical and mental illnesses;
 - (iii) Claims experience;
 - (iv) Receipt of health care;
 - (v) Medical history;
 - (vi) Genetic information;
 - (vii) Evidence of insurability, including conditions arising out of acts of domestic violence; or
 - (viii) Disability.

Drafting Note: This definition tracks the language contained in Public Health Service Act Section 2702(a), as amended by HIPAA.

Discontinuance and Replacement Regulation

- (2) (a) Each person not covered under the succeeding carrier's plan of benefits in accordance with Paragraph (1) shall nevertheless be covered by the succeeding carrier in accordance with the following rules if the individual was validly 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 succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.
 - (b) The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.
 - (c) Coverage shall 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 Paragraph (1);
 - (ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage, such as at termination of employment or ceasing to be an eligible dependent; or
 - (iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which Section 6 of this regulation requires an extension of benefits or accrued liability, the end of any period of extension benefits or accrued liability that is required of the prior carrier by Section 6 of this regulation, or if the prior carrier's policy, contract or certificate is not subject to that section, but would have been required of the prior carrier had the policy, contract or certificate been subject to Section 6 of this regulation at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan.
- (3) For health insurance coverage, in the case of an individual who was totally disabled at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan, and in the case in which Section 6 of this regulation requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits paid by the prior plan.

- (4) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of individuals becoming covered by the succeeding carrier's plan in accordance with this paragraph during the period of time this limitation applies under the new plan shall 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.
- (5) The succeeding carrier, in applying any deductibles or coinsurance amounts applicable to the out-of-pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the ninety (90) days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision.
- (6) In any situation where 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 the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier.

Section 8. Effective Date

This regulation shall take effect on [insert a date at least 120 days after promulgation].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1972 Proc. II 10, 13, 410, 483, 484-487 (adopted).

2002 Proc. 1st Quarter 218-222 (model adopted later is printed here).

2002 Proc. 2nd Quarter 14, 15, 166, 168-169 (amendments adopted).

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**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

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**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	ARIZ. ADMIN. CODE 20-6-210 (1979/2007).	
Arkansas		ARK. CODE ANN. § 23-86-116 (1987/2001); § 23-86-311 (1997/2003) (Notice).
California		CAL. INS. CODE §§ 10128 to 10128.59 (1977/2003); § 10133.56 (1998/2004).
Colorado	COLO. REV. STAT. § 10-16-106 (1992/1999) (§ 7 only).	
Connecticut	CONN. AGENCIES REGS. §§ 38a-546-1 to 38a-546-5 (1985/2010).	CONN. GEN. STAT. §§ 38a-537 (1982) (Discontinuance).
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	

**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Florida		FLA. STAT. §§ 627.666 to 627.667 (1975/1992).
Georgia	GA. COMP. R. & REGS. 120-2-10-.10 (1967/1990).	
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho		IDAHO CODE ANN. §§ 41-2211 to 41-2215 (1978).
Illinois	ILL. ADMIN. CODE. tit. 50, §§ 2013.10 to 2013.70 (1990/1994).	I.C. ILL. COMP. STAT. § 367i (1990).
Indiana	NO CURRENT ACTIVITY	
Iowa	NO CURRENT ACTIVITY	
Kansas	NO CURRENT ACTIVITY	
Kentucky	KY. REV. STAT. ANN. §§ 304.18-124 to 304.18-127 (1990).	
Louisiana		LA. REV. STAT. ANN. § 22:215.6 (1977/1997).
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 2847-A to 2850 (1990/2009).
Maryland	NO CURRENT ACTIVITY	
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota	MINN. R. §§ 2755.0100 to 2755.0500 (1984/1989) (§ 7 only).	
Mississippi	MISS. CODE ANN. § 83-9-35 (1982/1993) (Contains most of § 7 from model).	

**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Missouri	MO. REV. STAT. §§ 376.431 to 376.442 (1986).	
Montana	NO CURRENT ACTIVITY	
Nebraska	NO CURRENT ACTIVITY	
Nevada		NEV. REV. STAT. § 689B.065 (1987).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. 1901.05 (1982/1990) (Health).	N.H. CODE ADMIN. R. ANN. INS. 401.01(d)(2)d (1982) (Life) 1901.08 (2006) (Health); 1902.08 (2006) (Health); 1906.04 (2006) (Health); 1906.06 (2006) (Health).
New Jersey	N.J. ADMIN. CODE §§ 11:2-13.1 to 11:2-13.9 (1975/2000).	
New Mexico	13 N.M. CODE R. §§ 10.5.1 to 10.5.13 (1997/1998).	
New York	NO CURRENT ACTIVITY	
North Carolina		N.C. GEN. STAT. § 58-51-110 (1989) (Replacement).
North Dakota	N.D. ADMIN. CODE 45-08-02-01 to 45-08-02-07 (1988/2004).	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma	OKLA. STAT. tit.36, §§ 4509 to 4509.1 (1988/1992) (§ 7 of model only).	
Oregon	OR. ADMIN. CODE 836-82-050 to 836-82-055 (1990) (§ 7 only).	
Pennsylvania	NO CURRENT ACTIVITY	

**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	27-23 R.I. CODE R. §§ 901 to 905 (1978).	
South Carolina	S.C. CODE ANN. § 38-71-760 (1988/2002).	
South Dakota		S.D. CODIFIED LAWS § 58-18-7.11 (2009).
Tennessee	NO CURRENT ACTIVITY	
Texas		TEX. INS. CODE ANN. §§ 1251.251 to 1251.255 (2005/2009); §§ 1251.301 to 1251.310 (2005).
Utah	NO CURRENT ACTIVITY	
Vermont	Vt. STAT. ANN. tit. 8, §§ 4091a to 4091f (1989).	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington	NO CURRENT ACTIVITY	
West Virginia	NO CURRENT ACTIVITY	
Wisconsin	Wis. ADMIN. CODE INS. § 6.51 (1982).	
Wyoming	WYO. STAT. ANN. §§ 26-19-201 to 26-19-204 (1989) (Replacement).	

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

Proceedings Citations

Cited to the Proceedings of the NAIC

The model was amended in 2002. The chair reported that amendments were being developed to conform to the provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). **2000 Proc. 4th Quarter 172.**

When the task force requested comments on the proposed amendments, the only comment received did not focus on the HIPAA amendments, but rather on other provisions of the model. The chair noted that the charge was to revise relevant NAIC models to conform to HIPAA requirements. It would not be within the scope of the group's charge to take action on other issues. He said that the task force could review the model more extensively in the future, since it had been a long time since it was adopted. **2001 Proc. 1st Quarter 108.**

When the model was brought before the Executive Committee for adoption, the commissioner reporting on the model said no significant issues were raised and all stakeholders were agreeable to the amendments. **2002 Proc. 2nd Quarter 14.**

Section 1. Authority

It was a suggestion of an advisory committee that the insurance commissioners of most states have sufficient authority within the insurance statutes to affect resolution of the identified problems by means of appropriate administrative rules. **1972 Proc. I 608.**

Section 2. Scope

The model was designed to apply to all group and group-type coverage for employees or union or association members. It was intended to include group insurance, the Blue's group remittance plans, and wholesale and franchise plans. **1972 Proc. II 483.**

At the same time nonprofit health service plans (Blue Cross Blue Shield) were added to the definition of carrier in Section 3, the scope section was revised to remove the reference to nonprofit health service plans. **2002 Proc. 1st Quarter 184.**

Section 3. Definitions

A. The definition of carrier was added when amendments were being developed in 2001. It was added because the term was used throughout the model. The intent behind the proposed definition was to make sure that those insurers subject to the model were captured, but those not already subject to the model were not captured. Staff noted that this model was not limited to health insurers and included others, such as life insurers. **2001 Proc. 4th Quarter 222.**

A regulator opined that Blue Cross Blue Shield plans might not be included in the proposed definition, depending on how they were defined in state law. Staff said the model already applied to these plans, as they were included in Section 2 of the model, which referred to nonprofit service corporations. She agreed to revise the definition to clarify it. **2001 Proc. 4th Quarter 222.**

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 3 (cont.)

By the next meeting staff reported that the definition of carrier had been altered to include nonprofit health service plans. **2002 Proc. 1st Quarter 184.**

B. Group-type plan was defined so as to exclude salary savings or salary budget plans. **1972 Proc. II 483.**

C. By the time the third draft of revisions to the model had been prepared, a definition of health insurance coverage was added to Section 3. The definition was consistent with HIPAA's definition and was included because of proposed revisions to Section 7C. **2002 Proc. 1st Quarter 184.**

Section 4. Effective Date of Discontinuance for Non-Payment of Premiums or Subscription Charges

The Task Force to Explore Problems Relating to Employer-Employee Group Coverages pinpointed several serious problems relating to group coverage. Most of these involved failure to forward payments collected from individual insured persons or failure to give notice of the discontinuance or alteration of the group policy. Several commissioners indicated that in particular situations they had encouraged group insurers to provide coverage when it seemed there had not been complete communication. Representatives of insurers contended that the group mechanism would not work effectively unless the group policyholder was given sole responsibility for many of the ministerial functions involved in soliciting and administering the group coverage. **1971 Proc. II 409.**

Principles set forth by an industry advisory committee included the following: if coverage is continued beyond the expiration of the grace period by action of the carrier, the carrier should be liable for claims incurred thereafter until it gives written notice of discontinuance to the employer. **1972 Proc. II 482.**

Section 5. Requirements for Notice of Discontinuance

A committee was appointed to consider the problem of the responsibilities of an insurer and employer to insured employees upon termination of a group insurance policy, with particular emphasis on the matter of notice to employees where coverage has been changed or terminated or the identity of the insurer changed. **1971 Proc. I 207.**

When the NAIC began to consider the problem of notice of discontinuance, a statement prepared by insurance representatives argued that no action by the NAIC was necessary. They said the problem was not widespread, that employees were more concerned about getting their paychecks when their company faced financial difficulty, and that requiring insurers to provide notice to the employees would seriously impair the group mechanism for providing insurance. **1971 Proc. I 211.**

Recommendations by the task force included a requirement that the contract form should make it the insurer's responsibility to notify covered persons in advance of any lapse, termination or change in coverage. **1971 Proc. II 410.**

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 5 (cont.)

A group of insurance representatives discouraged the concept of requiring the insurer to give notice to the employees if payment was not made, because the insurer did not have addresses of the insureds. Requiring the employer to send notices for the insurer would also not be appropriate because the employer was not, under most jurisdictions' laws, an agent of the insurer. An employer unscrupulous enough to continue withholding employee contributions after termination of coverage was not likely to cooperate with the insurer in seeing that notice of termination was given to the employees. **1971 Proc. I 211.**

Insurers maintained that requiring them to provide notice of discontinuance would increase the cost of providing coverage. One of the basic reasons for the existence of group insurance policies was the lower cost of the insurance to the policyholder and insured persons. The fact that the insurer would deal with only one person, rather than with each member of the group separately, would result in a lower cost to the insurer and the resulting savings would be passed on to the group. **1971 Proc. I 211.**

No one section of this regulation was the subject of more discussion than this section which contained requirements for notice of discontinuance. One commissioner suggested that the insurer should be responsible for seeing that all policyholders were notified of termination. In the event the policyholder failed to do so, the insurer would be responsible for mailing notification to the last address of each certificateholder as shown by the records of the policyholder. The task force decided to defer action on that suggestion. **1972 Proc. I 555-556, 608.**

An industry advisory committee report included the following recommendation: The employer should be requested to notify employees of termination of coverage and warned about his liability if collection of premiums continued. **1972 Proc. II 482.**

Section 6. Extension of Benefits

One of the key features of the new model being drafted was its provision that all new contracts, and existing contracts at renewal, must provide for reasonable extension of benefits during total disability. An extension of at least 12 months was required for major medical and comprehensive medical coverage. For other hospital and medical coverage an extension of 90 days was required. **1972 Proc. II 482-483.**

E. Paragraph (2) was added as a part of the amendments adopted in 2002. **2002 Proc. 1st Quarter 220.**

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 7. Continuation of Coverage in Situations Involving Replacement of One Carrier by Another

After deciding it was appropriate that contracts should require that all existing covered persons should be covered under the new contract on change of insurer, a task force began drafting appropriate model legislation. **1971 Proc. II 410.**

An industry advisory committee recommended that employers be protected against loss as a result of change in carriers. The prior carrier remained liable only to the extent of accrued liabilities and extensions. The succeeding carrier must cover all persons eligible for coverage in accordance with its plan of benefits. This section established rules for the coverage of other persons covered by the prior carrier who were members of the class eligible for coverage under the succeeding carrier's plan. For other persons a minimum level of benefits was required at the level of the prior carrier's plan, and coverage must be continued for certain minimum periods as specified. If the succeeding carrier's plan contained a preexisting condition exclusion, the insured nevertheless would receive at least the benefit of the prior plan or the benefits of the new plan without regard to the preexisting condition limitation, whichever is lesser. The regulation contained provisions designed to give the insured credit, under the succeeding carrier's plan, for the satisfaction of any deductible or waiting period provisions of the prior plan. When the succeeding carrier is to pay benefits at the level of the prior plan, the prior carrier shall furnish upon request the information that the succeeding carrier needs for this purpose. **1972 Proc. II 483.**

When the NAIC committee announced that amendments would be developed to comply with the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA), staff began preparation of draft amendments. She said a bulletin had recently been issued by a federal agency that expressed the agency's position with respect to Section 7 of the model and a provision in that section that referred to "actively-at-work" and "nonconfinement" policy clauses as these clauses affected an individual's eligibility for enrollment under a succeeding health benefit plan. **2000 Proc. 4th Quarter 177-178.**

Amendments to Section 7 would be necessary because it established requirements regarding the liability of the prior carrier and the succeeding carrier after the date of discontinuance of a policy or contract when the policy or contract was replaced with a similar policy or contract. **2000 Proc. 4th Quarter 178.**

B. An interested party submitted a letter commenting on the confusion regarding industry practice and interpretation regarding hospital confinements. He said that prior to the enactment of HIPAA, the prior carrier was responsible for payment of benefits for a hospital confinement that extended beyond the plan's termination date. The succeeding carrier was not responsible. Since the enactment of HIPAA, there had been various state interpretations as to carrier responsibility. Some states required the prior carrier to remain responsible for coverage, while others required the succeeding carrier to provide the coverage. The commenter recommended that the model regulation be amended to expressly require the prior carrier to remain responsible. **2002 Proc. 2nd Quarter 168.**

**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

Proceedings Citations
Cited to the Proceedings of the NAIC

Section 7B (cont.)

The chair stated that he believed the recommendation was beyond the scope of the charge, but that the task force could ask for a new charge in the future to address the issue. **2002 Proc. 2nd Quarter 168-169.**

C. Subsection C was redrafted to conform to the requirements of HIPAA. Paragraph (1) was revised to require the succeeding carrier to enroll and provide coverage to an eligible individual requesting enrollment regardless of any actively-at-work or nonconfinement rules. **2000 Proc. 4th Quarter 178.**

Staff first suggested deleting Paragraph (2) as unnecessary because it established requirements for the succeeding carrier to provide coverage for any eligible individual requesting enrollment despite any actively-at-work or nonconfinement rules. Paragraph (1) was revised to require all eligible individuals requesting enrollment to be enrolled in a succeeding carrier's plan, so it appeared that Paragraph (2) was no longer needed. **2000 Proc. 4th Quarter 178.**

At a later meeting staff reported that, upon further review of the bulletin issued by the federal agency, it appeared that the actively-at-work provision would still be permitted under HIPAA, but it could not discriminate against an individual based on a health status related-factor. **2001 Proc. 4th Quarter 221-222.**

A proposed change to Subsection C would permit a carrier to have an actively-at-work provision in the plan as long as that provision provided that absence from work due to any health status-related factor was treated as actively at work. **2001 Proc. 4th Quarter 222.**

A definition of health status-related factor was added to Section 7C that tracked the language found in HIPAA. **2001 Proc. 4th Quarter 222.**

Paragraph (1)(b) was added near the end of the drafting process to avoid impacting other types of insurers, such as life insurers, with the requirements under HIPAA for health insurers regarding nonconfinement clauses and actively-at-work provisions. **2002 Proc. 1st Quarter 184.**

Staff noted that other changes were made to Section 7 to include references to other types of cost-sharing that were not in wide use when the model was originally adopted in 1972. **2001 Proc. 4th Quarter.**

Paragraph (3) was added near the end of the drafting process. **2002 Proc. 1st Quarter 221.**

**GROUP COVERAGE DISCONTINUANCE AND
REPLACEMENT MODEL REGULATION**

Proceedings Citations
Cited to the Proceedings of the NAIC

Chronological Summary of Actions

June 1972: Model adopted.

September 2002: Model amended to coordinate with federal Health Insurance Portability and Accountability Act (HIPAA).