

## GROUP HEALTH INSURANCE MANDATORY CONVERSION PRIVILEGE MODEL ACT

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### Section 1. Title

This Act shall be known and may be cited as the Group Health Insurance Mandatory Conversion Privilege Act.

**Drafting Note:** In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

### Section 2. Definitions

For purposes of this Act:

- A. “Commissioner” means the Commissioner of Insurance.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- B. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

- C. “Dependent” shall be defined in the same manner as in [insert reference to state insurance law defining dependent].

**Drafting Note:** States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the employee.

“Dependent” means a spouse, an unmarried child under the age of [nineteen (19)] years, an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the employee or member, and an unmarried child of any age who is medically certified as disabled and dependent upon the employee or member.

- D. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

- E. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

- F. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- G. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of health care services on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.
- H. “Medicare” means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

**Section 3. Applicability and Scope**

- A. Except as provided in Subsection B, this Act shall apply to any group health benefit plan delivered or issued for delivery in this state.
- B. The provisions of this Act shall not apply to a health benefit plan that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity or other fixed indemnity coverage, long-term care insurance, as defined by [insert reference in state law that defines long-term care insurance], vision care or any other supplemental benefit or to a Medicare supplement policy, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers’ compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

**Section 4. Conversion Privilege**

- A. Any health carrier providing coverage under a group health benefit plan shall provide that an employee or member whose coverage under the plan has been terminated for any reason, including discontinuance of the group health benefit plan in its entirety or with respect to an insured class, and who has been continuously covered under the group health benefit plan and under any group health benefit plan providing similar benefits which it replaces for at least three (3) months immediately prior to termination is entitled to have issued to him or her a converted policy, without evidence of insurability, subject to the provisions of this Act.
- B. A health carrier shall include a notice of the right of conversion in each certificate of coverage.
- C. An employee or member or a dependent of an employee or member shall not be entitled to a converted policy if termination under the group health benefit plan occurred because:
  - (1) The employee or member failed to pay any required premium or contribution;
  - (2) The employee or member or dependent performed an act or practice that constitutes fraud in connection with the coverage;
  - (3) The employee or member or dependent made an intentional misrepresentation of a material fact under the terms of coverage; or
  - (4) The terminated coverage under the group health benefit plan was replaced by similar coverage within thirty-one (31) days after the date of termination.

- D. Written application for the converted policy shall be made and the first premium paid to the health carrier no later than thirty-one (31) days after the date of termination of coverage under the group health benefit plan.
- E. The effective date of the converted policy shall be the day following the date of termination of coverage under the group health benefit plan.

**Section 5. Conversion Premium**

- A. Subject to Subsection B, the initial premium for the converted policy for the first twelve (12) months and subsequent renewal premiums shall be determined in accordance with the health carrier's premium rates applicable to individually underwritten standard risks, to the age and class of risk of each individual to be covered under the converted policy and to the type and amount of coverage provided. The experience under converted policies shall not be an acceptable basis for establishing rates for converted policies.

Alternate No. 1

- B. If a health carrier experiences incurred losses, for a period of two (2) years, on conversion policies that have been in force for at least one year, which exceed earned premiums by more than twenty percent (20%), the health carrier may file with the commissioner amended renewal rates for the subsequent year, that will produce a loss ratio of not less than 120%.

**Drafting Note:** The above subsection should be inserted in states that have rate review authority.

Alternate No. 2

- B. If a health carrier experiences incurred losses, for a period of two (2) years, on conversion policies that have been in force for at least one year, which exceed earned premiums by more than twenty percent (20%), the health carrier may amend renewal rates for the subsequent year, that will produce a loss ratio of not less than 120%.

**Drafting Note:** The above subsection should be inserted in states that do not have rate review authority.

- C. Conditions pertaining to health status shall not be an acceptable basis for classification for the purposes of this section. The frequency of premium payment shall be the frequency customarily required by the health carrier for the policy form and plan selected, provided that the health carrier shall not require premium payments less frequently than quarterly.

**Drafting Note:** Because converted policies generally comprise a substandard class of risk, rates based on the experience of converted policies would reflect substandard morbidity. As a result, rates for policies that provide an acceptable level of benefits may very well require premiums that would be out of reach for the average converting person. In effect, such rates are based on the assumption that the converting person is a substandard risk. Such an assumption runs counter to the intent of this model law. It serves no purpose to require issue of a converted policy without evidence of insurability if the insurer is allowed to automatically assume the converting person is substandard and charge an accordingly high premium.

It is understood that premiums based on standard morbidity assumptions will generally be inadequate as is the case in life insurance conversions. It is also understood that the rate inadequacy may be handled in much the same manner as life insurance conversions by spreading the extra cost over the group business through conversion charges to the group or through an extra charge in the group premium.

**Section 6. Scope of Coverage**

The converted policy shall cover the employee or member and any dependents, who were covered under the group health benefit plan on the date of termination of coverage. At the option of the health carrier, a separate converted policy may be issued to cover any dependent.

**Section 7. Exceptions to Guaranteed Coverage**

- A. A health carrier shall not be required to issue a converted policy covering an individual if the individual:
  - (1) Is or could be covered by Medicare;
  - (2) Is covered for similar benefits by another individual health benefit plan; or

- (3) Is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis or similar benefits are provided or are available to the individual in accordance with any state or federal law and together with the converted policy's benefits would result in overinsurance according to the health carrier's standards for overinsurance.
- B. The health carrier's standards for overinsurance, referenced under Subsection A(3), shall bear some reasonable relationship to actual health care service costs in the area in which the individual lives at the time of conversion and shall be filed with the commissioner prior to their use in denying coverage.

**Section 8. Information Requested by Health Carrier**

A converted policy may include a provision permitting the health carrier to request information in advance of any premium due date of the policy of any individual covered under the policy as to whether:

- A. The individual is covered for similar benefits under another health benefit plan or any other plan or program;
- B. The individual is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- C. Similar benefits are provided for or available to the individual in accordance with the requirements of any state or federal law.

**Section 9. Exceptions to Guaranteed Renewal**

- A. A converted policy may permit the health carrier to refuse to renew the policy or the coverage of any individual covered under the policy for any of the following reasons only:
  - (1) The individual failed to pay premiums or contributions in accordance with the terms of the converted policy, including timeliness requirements;
  - (2) The individual performed an act or practice that constitutes fraud in connection with coverage;
  - (3) The individual made an intentional misrepresentation of a material fact under the terms of coverage;
  - (4) For a network plan, the individual no longer lives, resides or works in the health carrier's service area or the area for which the health carrier is authorized to do business, provided coverage is terminated without regard to any health status-related factor relating to any covered individual; or
  - (5) Any other reason approved by the commissioner.

**Drafting Note:** As noted in the preamble to the interim final rules implementing the individual market provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), "a conversion policy is an individual policy, not a group policy, even though prior group coverage is a prerequisite to qualifying for the conversion policy." 62 Fed. Reg. 16987 (April 8, 1997). As such, with respect to Paragraph (5), states should be aware that Public Health Service Act (PHSA) Section 2742, as added by HIPAA, lists specific exceptions to guaranteed renewability in the individual market. States may want to review PHSA Section 2742 prior to adding other exceptions to guaranteed renewal. States also should be aware that PHSA Section 2742 does not contain an exception to guaranteed renewability in the case of an individual attaining eligibility for Medicare. However, also as noted in the preamble to the interim final rules, if permitted by state law, policies that are sold to individuals before they obtain Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays. 62 Fed. Reg. at 16989 (April 8, 1997).

- B. For purposes of this section:
  - (1) "Health status-related factor" means any of the following factors:
    - (a) Health status;
    - (b) Medical condition, including both physical and mental illness;
    - (c) Claims experience;

- (d) Receipt of health care;
- (e) Medical history;
- (f) Genetic information;
- (g) Evidence of insurability, including conditions arising out of acts of domestic violence; or
- (h) Disability.

**Drafting Note:** This definition tracks language contained in PHSA Section 2702(a), as amended by HIPAA.

- (2) “Network plan” means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as health care services, are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

#### **Section 10. Level of Benefits to be Offered**

A health carrier shall issue a converted policy that conforms to the requirements as prescribed by the commissioner.

#### **Section 11. Excess Benefits**

A health carrier shall not be required to issue a converted policy that provides benefits in excess of those provided under the group health benefit plan from which conversion is made.

#### **Section 12. Preexisting Condition Provision**

The converted policy shall not exclude a preexisting condition not excluded by the group health benefit plan. However, the converted policy may provide that any hospital, surgical or medical benefits payable under the policy may be reduced by the amount of any such benefits payable under the group health benefit plan after the termination of the individual’s group coverage. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group health benefit plan, shall not exceed the benefits that would have been payable had the individual’s coverage under the group health benefit plan remained in force and effect.

#### **Section 13. Alternative Plans**

A health carrier may offer alternative plans for group health benefit plan conversion in addition to those required by this Act.

#### **Section 14. Other Conversion Privileges**

- A. If coverage would have been continued for an employee under the group health benefit plan following the employee’s retirement prior to the time the employee is or could be covered by Medicare and provided that the employee would have been eligible for continuation of coverage under the group health benefit plan, the employee may elect, instead of continuing coverage under the group health benefit plan, to have the same conversion rights as would apply had the employee’s coverage under the group health benefit plan terminated at retirement by reason of termination of employment or membership.
- B. The conversion privilege provided in this Act shall be available to:
  - (1) The surviving spouse at the death of an employee or member, with respect to the spouse and any dependent children whose coverage under the group health benefit plan terminates by reason of that death or, if the group health benefit plan provides for continuation of dependent coverage following the employee’s or member’s death, at the end of the continuation coverage;
  - (2) Each surviving dependent child at the death of an employee or member whose coverage under the group health benefit plan terminates by reason of that death or, if the group health benefit plan provides for continuation of dependent coverage following the employee’s death, at the end of the continuation coverage;

- (3) The spouse of an employee or member upon the termination of coverage of the spouse under the group health benefit plan because the spouse becomes ineligible for coverage under that plan because of divorce, separation or otherwise, while the employee or member remains covered under the group health benefit plan, with respect to the spouse and any dependent child whose coverage under the group health benefit plan terminates at the same time; or
- (4) A dependent child solely with respect to the dependent child only upon termination of the dependent child's coverage under the group health benefit plan by reason of ceasing to be eligible for coverage under the group health benefit plan, if a conversion privilege is not otherwise provided under the provisions of this Act with respect to the termination.

**Section 15. Reduction of Coverage Due to Medicare**

A converted policy may provide for reduction of coverage on any individual upon the individual's eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

**Section 16. Group Coverage Instead of Individual Coverage**

A health carrier may elect to provide coverage under a group health benefit plan instead of issuing a converted policy.

**Section 17. Out-of-State Conversions**

A converted policy that is delivered outside this state shall be on a form which could be delivered in any other jurisdiction as a converted policy had the group health benefit plan been issued in that jurisdiction.

**Section 18. Effective Date**

The provisions of this Act shall take effect [insert a date not less than twelve (12) months after the date of enactment] and shall apply to group health benefit plans delivered, issued for delivery or amended on or after this date.

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

*1976 Proc. 17, 10-11, 381, 386-387, 493, 494-499 (adopted).*

*2005 Proc. 1<sup>st</sup> Quarter 217, 262 (amended adopted by parent committee).*

*2005 Proc. 2<sup>nd</sup> Quarter 49, 58-67 (reprinted and adopted by Plenary).*

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**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.**

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**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. REV. STAT. ANN. § 20-377; § 20-1408 (1985).
Arkansas		ARK. CODE ANN. § 23-86-115 (1985/2001); BULLETIN 18A-2013 (2013).
California		CAL. INS. CODE §§ 12670 to 12692.5 (1981/2013).
Colorado	COLO. REV. STAT. § 10-16-108 (1992/2013).	
Connecticut	NO CURRENT ACTIVITY	
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	
Florida	FLA. STAT. § 627.6675 (1978/1985).	
Georgia	GA. COMP. R. & REGS. 120-2-10-11 (1986/1990).	GA. CODE ANN. § 33-24-21 (1981/2009) (Relating to spousal conversion rights in group health policies); § 33-2456 (1995).

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<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>RELATED STATE ACTIVITY</b>
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	NO CURRENT ACTIVITY	
Illinois	215 ILL. COMP. STAT. 5/367e.1 (1979/2003).	
Indiana	NO CURRENT ACTIVITY	
Iowa	IOWA CODE § 509.B4 (1947/1986).	
Kansas	KAN. STAT. ANN. § 40-2209(D) (1981/1994).	
Kentucky		KY. REV. STAT. ANN. §§ 304.18-110 to 304.18-120 (1974/1986).
Louisiana	LA. REV. STAT. ANN. § 22:230.2 (1992).	
Maine	ME. CODE R. § 281(1985).	ME. REV. STAT. ANN. tit. 24-A, § 2809-A (1981); tit. 24, §§ 2330 to 2331 (1981) (Nonprofit Service Reg.)
Maryland		MD. ANN. CODE art. 48A, §§ 477K; 477N (1977/1983); MD. CODE REGS. §§ 31.11.01.01 to 31.11.01.17 (1983/2015); BULLETIN 10-2008.
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota		MINN. STAT. § 62A.21 (1981/2013); BULLETIN 2013-3 (2013).
Mississippi	NO CURRENT ACTIVITY	
Missouri	MO. REV. STAT. §§ 376.397 to 376.403 (1981).	
Montana		MONT. CODE ANN. §§ 33-22-508 to 33-22-511 (1981/1991).

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<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>RELATED STATE ACTIVITY</b>
Nebraska	NO CURRENT ACTIVITY	
Nevada	NO CURRENT ACTIVITY	
New Hampshire		N.H. REV. STAT. ANN. § 415:18 VII to XI (1941/1990).
New Jersey	NO CURRENT ACTIVITY	
New Mexico		N.M. STAT. ANN. § 59A-18-16 (1985).
New York		N.Y. INS. LAW § 3221(e) (1984/2013).
North Carolina	N.C. GEN. STAT. §§ 58-53-45 to 58-53-115 (1981).	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. § 3923.122 (1975/1980); suspended 1-1-2014 thru 1-1-2018 – see S.B. 9 (2013)).
Oklahoma		OKLA. STAT. tit. 36, § 4502.1. (1981) (Limited right).
Oregon	NO CURRENT ACTIVITY	
Pennsylvania	40 PA. CODE. § 39-110 (1977).	
Puerto Rico		P.R. LAWS ANN. tit. 26, § 1707 (1975/1977).
Rhode Island	27 R.I. CODE R. §§ 23-801 to 23-803 (1978).	
South Carolina	S.C. CODE ANN. § 38-71-770 (1987/1990).	
South Dakota		S.D. CODIFIED LAWS §§ 58-18-7 to 58-18-7.6 (1984/1989); § 58-18-7.11 (2009).
Tennessee	TENN. CODE ANN. §§ 56-7-1502 to 56-7-1511 (1980).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Texas		TEX. INS. CODE ANN. §§ 1251.256 to 1251.260 (2005); 28 TEX. ADMIN. CODE §§ 21.5301 to 21.5322 (2014).
Utah		UTAH CODE ANN. §§ 31A-30-101 to 31A-30-117 (1986/2014); § 31A-22-723 (2009).
Vermont	VT. STAT. ANN. tit. 8, §§ 4090d to 4090g (1984/1986) (portions of model).	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. § 38.2-3416; § 38.2-3541 (1986/1988).
Washington		WASH. REV. CODE §§ 48.21.260 to 48.21.270 (1984).
West Virginia	W. VA. CODE §§ 33-16A-1 to 33-16A-14 (1978/1990).	
Wisconsin		WIS. STAT. § 632.897 (1979/2013); WIS. ADMIN. CODE INS. §§ 3.41 to 3.45 (1981/1991).
Wyoming	WYO. STAT. ANN. §§ 26-22-201 to 26-22-202 (1981/1983).	

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**Proceedings Citations**

Cited to the Proceedings of the NAIC

In 1974 a group representing health insurers presented a proposal for standard provisions on group health insurance. One section covered the conversion privilege and another described the converted policy. **1974 Proc. II 495-498.** The Accident and Health Insurance Subcommittee appointed a task force to draft a model health insurance conversion privilege law. **1974 Proc. II 468.**

In 2004 a task force began to discuss amendments to the model. The model had been identified as in need of revision as part of the NAIC model law review initiative. For the most part, the revisions brought the model into compliance with NAIC model law drafting requirements. **2004 Proc. 3<sup>rd</sup> Quarter 685.**

**Section 1. Title**

This section was added when the model was revised in 2005. **2005 Proc. 1<sup>st</sup> Quarter 272.**

**Section 2. Definitions**

This section was added when the model was revised in 2005. None of the definitions was discussed in any detail during the deliberations. **2005 Proc. 1<sup>st</sup> Quarter 272-273.**

**Section 3. Applicability and Scope**

This section was added in the revisions developed during 2004. An interested party asked the task force to consider revising Section 3 to mirror the applicability language in the newborn children model draft, being revised by the task force during the same time period. The applicability language in the newborn draft was based on the Health Insurance Portability and Accountability Act (HIPAA) excepted benefits language. Without objection, the task force agreed to this requested revision. **2004 Proc. 4<sup>th</sup> Quarter 737.**

Most of the text of Section 3 was added during the redraft that took place in 2004 and 2005. **2005 Proc. 1<sup>st</sup> Quarter 273.**

**Section 4. Conversion Privilege**

During the redraft completed in 2005, one state expressed a concern that the term “member” had been struck throughout the draft. The concern was that, by striking that term, the provisions of this model would not apply to associations and other groups that were not employer-based. Staff stated that “member” was stricken only because the use of the term in this model did not seem to conform to the NAIC’s current model law drafting style. There was no reason why it could not be added back into the model. Without objection, the task force agreed to this revision. **2005 Proc. 1<sup>st</sup> Quarter 262.**

**Section 5. Conversion Premium**

Before adoption of the model, the two alternative paragraphs on rate setting were added. **1976 Proc. I 10.**

The industry representatives present at the drafting sessions were opposed to the mandate of standard morbidity assumptions in calculating rates for conversion policies. The task force felt this represented a significant departure from the goal envisioned in the development of the model. As a result, the model called for the mandatory use of standard morbidity assumptions in the calculation of rates for conversion policies. **1976 Proc. I 493.**

It was suggested by one industry group that the use of inadequate rates for group conversions would create serious problems for the industry. The business of insurance normally involved risk sharing by those falling in the same underwriting classification. Persons who were substandard or marginal should expect to pay higher premiums. Charging the cost of conversions back to employers would lead to higher costs for doing business. In times of economic recession when large numbers of persons might be laid off, the additional conversion charges could threaten the solvency of an employer. **1976 Proc. I 499.**

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Cited to the Proceedings of the NAIC

**Section 5** (cont.)

When the amendments adopted in 2005 were under development, there was little discussion of this section. The amendments to the section were mostly technical drafting changes. **2005 Proc. 1<sup>st</sup> Quarter 275.**

**Section 6. Scope of Coverage**

During the amendment process in 2004 and 2005, a few technical changes were made to this section. **2005 Proc. 275.**

**Section 7. Exceptions to Guaranteed Coverage**

Some employers cover employees over age 65 on a Medicare supplement basis, so one regulator suggested the model should allow those who had been covered on that basis to convert to a similar coverage. Another found fault with the inclusion of a provision eliminating the conversion privilege if the insured could have been covered by Medicare Part B, but chose not to accept the government-sponsored benefits. **1975 Proc. II 358.**

When the 2005 amendments were adopted, some changes were made to Section 7 to clarify that a health carrier would not be required to issue a converted policy to an individual if the person was covered or eligible for coverage under Medicare or was covered by other similar benefits, so that overinsurance would occur. **2005 Proc. 1<sup>st</sup> Quarter 276.**

**Section 8. Information Requested by Health Carrier**

The industry comments received before adoption suggested the addition of an additional reason the insurer might refuse to renew the coverage. They recommended allowing discontinuance of the class of policies to which the converted policy belonged as an allowable reason for nonrenewal. They suggested that the absence of such language made the policies noncancelable at inappropriate rates. Secondly, an insurer that wanted to get out of the health insurance business would be precluded from doing so. **1976 Proc. I 500.**

The changes adopted in 2005 were technical in nature. **2005 Proc. 1<sup>st</sup> Quarter 276.**

**Section 9. Exceptions to Guaranteed Renewal**

Some of the provisions of the original Section 7 became part of Section 9. When the revised draft was being discussed, staff noted that comments had been received from the Centers for Medicare and Medicaid Services (CMS) concerning Section 9. In its comments, CMS noted several provisions in this section that could be preempted under provisions in the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, conversion policies would be considered individual policies and HIPAA contained specific provisions that would allow a health carrier to nonrenew an individual policy. Those provisions included nonpayment of premium or fraud or misrepresentation in applying for the policy. Some of the provisions in Section 9 were not specified in HIPAA as a reason to nonrenew an individual policy, so there was the possibility that these provisions could be preempted under HIPAA. **2004 Proc. 4<sup>th</sup> Quarter 736.**

**Section 10. Level of Benefits to be Offered**

The regulators' drafting committee proposed keeping the benefits the same as had been offered in the group policy. The industry comments received suggested that carriers be required to offer conversion policies with just three levels of benefit plans. The converting individual could choose which of these plans would suite his needs and his pocketbook. If he was very hard-pressed financially and lived in a low medical expense area, he could choose the most modest plan. The comments also suggested a major medical benefit with a \$20,000 lifetime maximum and a \$500 deductible. **1975 Proc. II 357.**

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**Section 10** (cont.)

One regulator noted that her state had established two converted policy health benefit plans—basic and standard. The standard health benefit plan provided benefits that were substantially similar to those in the group health benefit plan that was being converted. The basic health benefit plan included basic minimum benefits. She said that more and more consumers were taking the basic health benefit plan because the standard health benefit plan was very expensive. **2004 Proc. 3<sup>rd</sup> Quarter 686.**

Staff explained that the proposed revisions deleted former Section 10—Optional Coverage—Hospitalization or Surgical Expense and former Section 11—Optional Coverage—Major Medical. Those sections set out, in great detail, including percentages and dollar amounts, requirements for hospitalization or surgical expense and major medical coverages that were to be provided in a converted policy if the group health benefit plan from which conversion was being made offered such coverage. It seemed unlikely that the percentages and dollar amounts referenced remained accurate since the model's adoption over 25 years ago. Given this, those sections would either have to be updated or some other approach taken in the revisions that would eliminate the need for that much specificity in a model law. The redrafted Section 10 was that other approach. It would require a health carrier to issue a converted policy that provided substantially similar benefits to those provided under the group health benefit plan from which conversion was made, but not less than the minimum standards established by the commissioner. **2004 Proc. 4<sup>th</sup> Quarter 736-737.**

One regulator suggested that the language be altered to require a health carrier to issue a converted policy that provided substantially similar benefits *and dollar amount of reimbursement* to those provided under the group health benefit plan from which conversion was made. The regulator with the basic and standard health plan again suggested that approach. The chair suggested altering the language in Section 10 to require a health carrier to issue a converted policy that conformed to the requirements prescribed by the commissioner. Without objection, the task force adopted that suggestion. **2004 Proc. 4<sup>th</sup> Quarter 737.**

**Section 11. Excess Benefits**

The first drafts of the model considered by the committee provided that each individual policy should provide coverage substantially similar to that included under the group policy. **1975 Proc. II 359.**

An industry trade group presented a statement in opposition to the concept that the replacement policy must provide substantially similar benefits. They opposed the concept as unworkable and not meeting the needs of the public. Group policies provided an infinite variety of health plans with widely varying levels of benefits. It would be unduly expensive to create a portfolio of individual policies providing the same vast array of benefit levels provided under group policies issued in a given jurisdiction. To require insurers to do so would be unworkable. Prices for the converted policies would be beyond what the converting individual could afford to pay. The cost of the converted policy would be so high that insureds would generally be unable to convert. **1975 Proc. II 357.**

The statement suggested that most people converting from group insurance to an individual policy did so to tide them over until they became insured again under some other group plan. Many were in a period of financial stress, so it was unreasonable to expect them to apply for a converted policy with rich benefit levels and corresponding high costs, just as it was unreasonable to require insurers to create a large portfolio of individual policies providing a wide variety of benefit levels. **1975 Proc. II 357.**

The changes to this provision adopted in 2005 were technical in nature. **2005 Proc. 1<sup>st</sup> Quarter 278.**

**Section 12. Preexisting Condition Provision**

Only a few technical changes were made during the drafting effort that culminated in the adoption of a revised draft in 2005. **2005 Proc. 1<sup>st</sup> Quarter 278.**

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**Section 13. Alternative Plans**

Only technical changes were made during the 2005 redraft. **2005 Proc. 1<sup>st</sup> Quarter 280.**

**Section 14. Other Conversion Privileges**

A. The text of Subsection A was the subject of technical changes in 2005. **2005 Proc. 1<sup>st</sup> Quarter 280.**

B. The text of Subsection B was added in 2005. **2005 Proc. 1<sup>st</sup> Quarter 280-281.**

**Section 15. Reduction of Coverage Due to Medicare**

Technical changes were made in 2005. **2005 Proc. 1<sup>st</sup> Quarter 281.**

**Section 16. Group Coverage Instead of Individual Coverage**

One regulator suggested that the option of continuing the group certificate would result in a lower expense loading and would be the method of choice. He encouraged the drafters to develop this concept further. **1975 Proc. II 358.**

Technical changes were adopted in 2005. **2005 Proc. 1<sup>st</sup> Quarter 281.**

**Section 17. Out-of-State Conversions**

A few technical amendments were included in the draft adopted in 2005. **2005 Proc. 1<sup>st</sup> Quarter 281.**

**Section 18. Effective Date**

A few technical amendments were included in the draft adopted in 2005. **2005 Proc. 1<sup>st</sup> Quarter 281.**

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*Chronological Summary of Action*

*December 1975: Adopted model.*

*June 2005: Model revised and updated. Several new sections added and several sections deleted.*