§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, limited-duration policies issued by insurers or health maintenance organizations. For purposes of this section, a short-term, limited-duration policy is an individual, nonrenewable policy issued for a term that does not extend beyond December 31st of the calendar year in which the policy is issued. This section does not apply to Medicare supplement policies as defined in section 5001, subsection 4.
[PL 2019, c. 330, §2 (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 or 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 [PL 2019, c. 330, §3 (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. [PL 2007, c. 199, Pt. D, §4 (AMD).]

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

D. [PL 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, limited-duration policy.
[PL 2019, c. 330, §3 (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; [PL 1997, c. 445, §26 (RPR); PL 1997, c. 445, §32 (AFF).]

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. [PL 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; [PL 1995, c. 332, Pt. F, §5 (AMD).]

C. [PL 1997, c. 777, Pt. B, §5 (RP).]

C-1. That person was covered by the Children's Health Insurance 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 [PL 2023, c. 597, §18 (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. [PL 1995, c. 332, Pt. F, §5 (NEW).]
[PL 2023, c. 597, §18 (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.
[PL 2009, c. 244, Pt. E, §4 (NEW).]

3-B. Persons subject to a preexisting condition exclusion.
[PL 2019, c. 5, Pt. A, §15 (RP).]

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.
[PL 2009, c. 244, Pt. E, §6 (AMD).]

4-A. Alternative method. The superintendent may adopt rules that substitute for the requirement of subsection 3-A 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).
[PL 2009, c. 511, Pt. D, §1 (AMD).]

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.
[PL 1989, c. 867, §8 (NEW); PL 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.
[PL 1989, c. 867, §8 (NEW); PL 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.
[PL 1993, c. 477, Pt. A, §14 (NEW); PL 1993, c. 477, Pt. F, §1 (NEW).]

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

A. Upon offering an individual short-term, limited-duration policy for purchase, an insurer or the insurer's agent or broker shall provide written disclosure as required in this paragraph in at least 14-point type. An insurer or the insurer's agent or broker shall specifically disclose:

(1) A summary of plan benefits, limits and exclusions in a standardized format similar to the format required for a qualified health plan under the federal Affordable Care Act that is specific to the exact policy being offered for purchase in this State, including, but not limited to, information about the circumstances in which covered benefits may be subject to balance billing and examples of how charges may be applied toward any cost sharing under the policy and billed to the individual policyholder; and

(2) A comparison of the short-term, limited-duration policy to a qualified health plan in the terms, benefits and conditions of the policy, any exclusions, medical loss ratio requirements or the provisions of guaranteed renewal and continuity of coverage. [PL 2019, c. 330, §4 (AMD).]

B. An insurer or the insurer's agent or broker may issue a short-term, limited-duration policy that replaces a prior short-term, limited-duration policy as long as the combined term of the new policy and all prior policies does not exceed 24 months and the individual has not been covered under any

prior short-term, limited-duration policy for at least 12 months. All individuals making an application for coverage under a short-term, limited-duration policy must disclose any prior coverage under a short-term, limited-duration policy and the policy duration. [PL 2019, c. 330, §4 (AMD).]

C. An insurer or the insurer's agent or broker may not issue a short-term, limited-duration policy unless it has been sold through an in-person encounter. [PL 2019, c. 330, §4 (NEW).]

D. An insurer or the insurer's agent or broker may not actively market or sell any short-term, limited-duration policy during any open enrollment period, except for a short-term, limited-duration policy that terminates coverage on December 31st of the calendar year in which it is sold. [PL 2019, c. 330, §4 (NEW).]

E. Upon offering an individual short-term, limited-duration policy for purchase, an insurer or the insurer's agent or broker shall assess an individual making an application for eligibility for an advanced premium tax credit or cost-sharing reduction for coverage under a qualified health plan purchased on the exchange pursuant to the federal Affordable Care Act, as defined in section 2188, subsection 1, paragraph A, and shall provide an estimate of the cost for coverage under a qualified health plan after applying any advanced premium tax credit or cost-sharing reduction. [PL 2019, c. 330, §4 (NEW).]

F. An insurer or the insurer's agent or broker shall make the documents and information required to be disclosed under paragraph A upon offering an individual short-term, limited-duration policy for purchase available through the insurer's publicly accessible website. [PL 2019, c. 330, §4 (NEW).]

G. An insurer or the insurer's agent or broker shall provide, upon the purchase of a short-term, limited-duration policy; upon the expiration of the policy; and, if the policy is in effect during an open enrollment period, on November 1st of the calendar year in which the policy was sold, written notice of the following:

(1) Disclosure that a short-term, limited-duration policy is not considered minimum essential coverage under the federal Affordable Care Act and that termination of a policy is not a qualifying event for a special enrollment period; and

(2) The dates for the next open enrollment period, the website address for the publicly accessible website of the exchange, as defined in section 2188, subsection 1, paragraph A, and the toll-free telephone number for the exchange. [PL 2019, c. 330, §4 (NEW).]

[PL 2019, c. 330, §4 (AMD).]

SECTION HISTORY

PL 1989, c. 867, §§8,10 (NEW). PL 1991, c. 695, §§9,10 (AMD). PL 1993, c. 477, §§A8-14 (AMD). PL 1993, c. 477, §F1 (AFF). PL 1993, c. 666, §D4 (AMD). PL 1995, c. 77, §2 (AMD). PL 1995, c. 332, §§F4,5 (AMD). PL 1995, c. 342, §§6-8 (AMD). PL 1995, c. 625, §B10 (AMD). PL 1995, c. 673, §B3 (AMD). PL 1997, c. 370, §C4 (AMD). PL 1997, c. 445, §§25-27 (AMD). PL 1997, c. 445, §32 (AFF). PL 1997, c. 777, §§B5,6 (AMD). PL 1999, c. 36, §§1-3 (AMD). PL 1999, c. 256, §L7 (AMD). PL 2001, c. 258, §§E7,8 (AMD). PL 2005, c. 683, §A42 (AMD). PL 2007, c. 199, Pt. A, §§4, 5 (AMD). PL 2007, c. 199, Pt. D, §4 (AMD). PL 2009, c. 244, Pt. E, §§4-6 (AMD). PL 2009, c. 511, Pt. D, §1 (AMD). PL 2011, c. 90, Pt. G, §§1, 2 (AMD). PL 2019, c. 5, Pt. A, §15 (AMD). PL 2019, c. 330, §§2-4 (AMD). PL 2023, c. 597, §18 (AMD).