

**PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS**

**Department of Health
and Human Services**

**Health Care Financing
Administration**

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Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: State “succeeding carrier” or “extension of benefits” laws and an issuer’s obligation under HIPAA to enroll an eligible individual who is disabled¹.

Markets: Group

I. Purpose

This bulletin conveys the position of the Health Care Financing Administration (HCFA) on the relationship between State “succeeding carrier” laws and the insurance reform provisions of Title XXVII of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A number of States enacted these laws prior to HIPAA to address the situation in which an employer with a disabled employee or dependent switches its group health plan coverage from one issuer (the “prior carrier”) to another (the “succeeding carrier”). This bulletin explains why a State succeeding carrier law cannot eliminate the succeeding carrier’s legal obligation under federal law to enroll an individual who is disabled at the time that the original health insurance coverage is terminated. However, as discussed below, this does not preclude State laws from promoting better outcomes by

¹The term “disabled individual,” is used in this bulletin to include an individual who is receiving inpatient hospital services on the date of replacement coverage or is covered under an extension of benefits provision. Similarly, the term “disability” is used herein to refer to the state of being hospitalized on the date of replacement coverage or covered under an extension of benefits provision.

imposing obligations over and above the Federal law requirements, or by providing rules for which a carrier will actually make payment in a particular situation.²

Because many State laws are based on the “Group Coverage Discontinuance and Replacement Model Regulation” adopted by the National Association of Insurance Commissioners (NAIC Model), this bulletin will set forth general principles based on the NAIC Model. A number of issuers and State regulators have inquired whether a State law based upon the Model is consistent with an issuer’s duties to provide coverage under the PHS Act. Even if a State’s law is not identical to the Model, the principles discussed here should provide useful guidance. For the reader’s convenience, a copy of the NAIC’s Group Coverage Discontinuance and Replacement Model Regulation is attached to this bulletin. The Model is published and copyrighted by the NAIC. Permission to reprint it here has been graciously given by the NAIC.

II. Background

A. NAIC Model.

Under the NAIC Model, when group health coverage is discontinued, the prior carrier must continue to provide benefits for a specified period of time for covered individuals who are totally disabled.³ This obligation is the same whether or not the group health plan purchases replacement coverage.

However, if the plan obtains replacement coverage that is similar to the old coverage, section 7.B describes the extent to which the prior carrier remains liable for any extension of benefits, while section 7.C addresses the obligations of the succeeding carrier. In particular, the Model addresses the situation in which an individual was disabled at the time the plan changed carriers, and the succeeding

²For example, while under the PHS Act the legal obligation of the succeeding carrier to enroll the individual for benefits is absolute, State law might provide that another carrier has the obligation to pay for the services, so that there is no cost (or a reduced cost) to the succeeding carrier for the benefits it would otherwise be legally obligated to cover.

³ Under Section 6.A of the Model, every policy or contract must provide “a reasonable provision for extension of benefits in the event of total disability at the date of the discontinuance of the group policy or contract.” Section 6.D specifies that for hospital or medical expense coverages other than dental and maternity, the requirement is satisfied by an extension of at least 12 months under comprehensive or “major medical” coverages, and at least 90 days under other types of hospital or medical expense coverages. This bulletin is only concerned with the types of coverages described in Section 6.D.

carrier has an “actively-at-work” or “nonconfinement” clause that would preclude coverage for the disabled individual.

B. PHS Act

The following provisions of the PHS Act control the interaction between that Federal statute and any succeeding carrier provisions that apply under State law.

1. Section 2702 of the PHS Act, 42 U.S.C. §300gg-1, states that issuers that offer coverage to group health plans “may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan” based on any of the listed “health status-related factors.” The statute makes clear that disability is one of these health factors. (Section 2702(a)(1)(H).)
2. Section 2701, 42 U.S.C. §300gg, permits an issuer to impose preexisting condition exclusions for group health insurance coverage, but places substantial restrictions on that ability. In general, the exclusion:
 - cannot be based on a medical condition if medical advice, etc. was not received during the six month period before the individual became covered under the group health plan, or began a waiting period for coverage
 - cannot last longer than 12 months (or 18 months for late enrollees)
 - must be reduced by creditable coverage
3. Section 2723(a) of the PHS Act, 42 U.S.C. §300gg-23(a), specifies that State laws will only be preempted under certain limited circumstances, which are discussed below.

C. Preemption – In General

“Preemption” is a term of art that refers to the situation in which Federal law supersedes State law. The courts have established guidelines for determining whether, and to what extent, State laws are preempted. The clearest indication of preemption is through the inclusion by Congress of an express preemption provision in a statute, such as in section 2723(a) of the PHS Act. That section specifies that State law will generally be preempted only if it “prevents the application of” a provision or requirement of Part A of Title XXVII. The legislative history indicates that this is intended to be the “narrowest” preemption of State laws.⁴

⁴ See House Conf. Rep. No. 104-736, at 205 (1996), reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

General case law on preemption provides additional guidance in determining what constitutes the scope of the preemption. One basis on which courts have found preemption is if compliance with both Federal and State law is, in effect, physically impossible. See Louisiana Public Service Commission v. Federal Communications Commission, 476 U.S. 355 (1986). In light of the statutory language that State law will not be preempted unless it “prevents” compliance with the PHS Act, the legislative history that indicates that preemption will be limited to the “narrowest” of circumstances, and the general case law on preemption, HCFA takes the position that State law “prevents the application” of a PHS Act provision if the State law makes it impossible for a party to comply with the PHS Act. If a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. The issuer simply could not take advantage of the State law provision.

This result is also consistent with Executive Order 13132 of August 4, 1999 (See 64 Fed. Reg. 43, 255 (August 10, 1999)), which states that “Agencies shall construe... a Federal statute to preempt State law only where the statute contains an express preemption provision or there is some other clear evidence that the Congress intended preemption of State law, or where the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute.”

III. Analysis

Section 7 of the NAIC Model appears to address the situation in which the succeeding carrier has an actively-at-work or nonconfinement clause that would permit the carrier to refuse to enroll a disabled individual who had been covered by the prior carrier. This provision predated the HIPAA amendments to the PHS Act, and these clauses are no longer permitted to the extent that they would deny enrollment of an individual because of a health factor. We have explained this analysis in Bulletin 00-01, with respect to nonconfinement clauses.⁵ We expect future regulations to address the issue of actively-at-work provisions. However, while such provisions may be permissible in some situations, an actively-at-work provision that is used to discriminate against an individual based on a health factor, such as disability, is not permitted.⁶

Section 7.C.(1) of the NAIC Model currently states:

⁵ A nonconfinement clause generally is a plan or policy provision that delays an individual’s effective date of coverage based on whether the individual is either: (1) confined to a hospital; (2) disabled; or (3) eligible for benefits under another plan’s or policy’s extension of benefits provision which is based on hospitalization or disability.

⁶This would include, for example, actively-at-work provisions that treat individuals on sick leave or disability leave less favorably than individuals on other types of leave.

“Each person who is eligible for coverage in accordance with the succeeding carrier’s plan of benefits (in respect of classes eligible and actively-at-work and nonconfinement rules) shall be covered by that carrier’s plan of benefits.” (Emphasis added.) If the underlined words are deleted, because nonconfinement clauses and certain actively-at-work clauses are impermissible under the PHS Act, then section 7.C.(1) of the Model would appear simply to require the succeeding carrier to enroll the disabled individual and provide coverage under the regular terms of the replacement policy. This would be consistent with the PHS Act, assuming the prior carrier covered the disabling condition. It would also seem to make section 7.C.(2) inapplicable, since that section addresses the responsibilities of the prior and succeeding carriers with respect to a disabled individual who cannot satisfy an actively-at-work or nonconfinement clause.

As noted above, section 2702 of the PHS Act contains an absolute legal prohibition against a carrier’s refusing to enroll an otherwise eligible individual based on a disability or other health factor. As also explained above, if a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. Thus if the State law purported to relieve a succeeding carrier of legal responsibility for enrolling an individual, on the basis that the individual was covered by a prior carrier under a State extension of benefits requirement, the State law would not apply.⁷

However, to the extent the State law requires coverage more extensive than required under the PHS Act, the State law could still apply. For example, in a situation that involves replacement coverage, the nondiscrimination provision of the PHS Act only applies to the succeeding carrier. Therefore, the State law obligation of the prior carrier is unaffected by the PHS Act requirement. If, for example, section 2701 of the PHS Act permitted the succeeding carrier to impose a preexisting condition exclusion on an individual’s disabling condition, the prior carrier’s extension of benefits obligation would presumably require it to provide coverage under State law.⁸

Some States have taken the position that succeeding carrier laws simply operate as coordination of benefits provisions. We believe that this may, as a practical matter, be true when all that is at

⁷We believe the State law would be preempted if it prohibited the succeeding carrier from covering the individual.

⁸We are providing this example for illustration, although this situation would only occur in the unlikely event that the succeeding carrier’s preexisting condition exclusion would meet all of the requirements of section 2701 of the PHS Act (i.e., the disabling event occurred prior to the individual’s enrollment date in the group health plan; the individual had been covered under the prior carrier for less than the maximum 12 months (18 months for a late enrollee); and the individual did not have enough other creditable coverage to completely eliminate the preexisting condition exclusion).

stake is which carrier pays for particular services. However, in a managed care environment we cannot agree that this is true as a legal matter. If, for example, a disabled individual was eager to switch to a provider that is only available through the succeeding carrier's network of providers, we do not believe that a State law could deny the individual the right granted by HIPAA to enroll in the succeeding carrier's coverage. We are sensitive to the fact that some States may view succeeding carrier laws as a way to protect certain disabled individuals from being suddenly required to change medical providers because of a change in carriers, where the carriers have limited provider networks. States are free to implement State requirements in a way that protects the interests of the disabled individuals without preventing the application of the Federal requirement. Since 1997, the PHS Act has clearly left it within the States' authority to enforce the nondiscrimination and preexisting condition exclusion provisions under their own laws. Therefore in the event there is any dispute about which carrier is required to provide coverage, States have the authority to enforce the various provisions in a way that guarantees that the individual is protected.

Where to get more information:

The regulations cited in this bulletin are found in Part 146 of Title 45 of the Code of Federal Regulations (45 CFR §146). Information about the PHS Act is also available on HCFA's website at <http://hipaa.hcfa.gov>.

If you have any questions regarding this Bulletin, call the HIPAA Insurance Reform Help Line at (410) 786-1565.

GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL REGULATION

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Section 1. Authority

This regulation is adopted and promulgated 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 an insurance company or a nonprofit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions [or associations].

Section 3. Definition

The term "group-type basis" means a benefit plan, other than "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

- A. 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;
- B. 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;
- C. There are arrangements for bulk payment of premiums or subscription charges to the insurer or nonprofit service corporation; and
- D. There is sponsorship of the plan by the employer, union [or association].

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 payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

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- 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 on which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the carrier shall not be liable for claims for losses incurred after that date. Notice of discontinuance shall also 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 will prepare and furnish to the policyholder or other entity at the same time a supply of notice forms to be distributed to the employees or members concerned, indicating the discontinuance and the effective date thereof, 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 discontinuance

Section 6. Extension of Benefits

- A. Every group policy or other contract subject to these rules and regulations hereafter issued, or under which the level of benefits is hereafter altered, modified or amended, shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract, as required by the following subsections of this section.
- B. In the case of a group life plan which 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 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 policy during a disability shall have no effect on benefits payable for that disability or confinement.
- D. 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. A provision will be considered "reasonable" if it provides an extension of at least twelve (12) months under "major medical" and "comprehensive medical" type coverages, and under other types of hospital or medical expense coverages provides either an extension of at least ninety (90) days or 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 which occurred while coverage was in force (e.g., an accident).

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- E. Any 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 or accrued liability may be subject to the policy's or contract's regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

Section 7. Continuation 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 contract replaces a plan of similar benefits of another.
- B. Liability of prior carrier. 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. Liability of Succeeding Carrier.
 - (1) Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier's plan of benefits.
 - (2) Each person not covered under the succeeding carrier's plan of benefits in accordance with Paragraph (1) above 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.
 - (a) 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.
 - (b) Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:
 - (i) The date the individual becomes eligible under the succeeding carrier's plan as described in Paragraph (1) above.
 - (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 (e.g., at termination of employment or ceasing to be an eligible dependent, as the case may be).

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- (iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which Section 6 requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by Section 6, or if the prior carrier's policy or contract is not subject to that section, would have been required of that carrier had its policy or contract been subject to Section 6 at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.
- (3) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons 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.
- (4) The succeeding carrier, in applying any deductibles 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, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible 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 provision.
- (5) In a 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 will 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 will 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].

Legislative History (all references are to the Proceedings of the NAIC).

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

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The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	NO ACTION TO DATE	
Alaska	NO ACTION TO DATE	
Arizona	ARIZ. ADMIN. COMP. R20-6-210 (1979).	
Arkansas		ARK. STAT. ANN. § 23-86-116 (1987).
California		CAL. INS. CODE §§ 10128 to 10128.4 (1977/1989); 10133.56 (1998).
Colorado	COL. REV. STAT. § 10-16-106 (1992) (§ 7 only).	
Connecticut	CONN. ADMIN. CODE tit. 38a §§ 546(b)-1 to 546(b)-6 (1985/1987).	CONN. GEN STAT. §§ 38a537 (1982) (Discontinuance).
Delaware	NO ACTION TO DATE	
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 627.666 to 627.667 (1975/1992).
Georgia	GA. ADMIN. COMP. ch. 120-2-10-.10 (1967/1990).	
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO CODE §§ 41-2211 to 41-2215 (1978).
Illinois	ILL. ADMIN. REG. tit. 50 §§ 2013.10 to 2013.70 (1990/1994).	ILL. REV. STAT. ch. I.C. § 367i (1990).
Indiana	NO ACTION TO DATE	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS/REGS.
Iowa	NO ACTION TO DATE	
Kansas	NO ACTION TO DATE	
Kentucky	KY. REV. STAT. §§ 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 (1990/1992).
Maryland	NO ACTION TO DATE	
Massachusetts	NO ACTION TO DATE	
Michigan	NO ACTION TO DATE	
Minnesota	MINN. INS. REG. 83 2755.0100 to 2755.0500 (1984/1989) (§ 7 only).	
Mississippi	MISS. CODE ANN. § 83-9-35 (1982/1993) (Contains most of § 7 from model).	
Missouri	MO. REV. STAT. §§ 38 376.431 to 376.442 (1986).	
Montana	NO ACTION TO DATE	
Nebraska	NO ACTION TO DATE	
Nevada		NEV. REV. STAT. § 689B.065 (1987).
New Hampshire	N.H. ADMIN. CODE INS. 1901.05 (1982/1990) (Health).	N.H. ADMIN. CODE INS. 401.01(d)(2)d (1982) (Life)
New Jersey	N.J. ADMIN. CODE §§ 11:2-13.1 to 11:2-13.9 (1975)(Amendments pending).	
New Mexico	N.M. INS. REGS. §§ 18-3-1 to 18-3-10 (1973).	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS/REGS.
New York	NO ACTION TO DATE	
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).	
Ohio	NO ACTION TO DATE	
Oklahoma	OKLA. STAT. tit.36 §§ 4509 to 4509.1 (1988/1992) (§ 7 of model only).	
Oregon	OR. ADMIN. R. 836-82-050 to 836-82-055 (1990) (§ 7 only).	
Pennsylvania	NO ACTION TO DATE	
Puerto Rico	NO ACTION TO DATE	
Rhode Island	R.I. REG. XXIII PART IX (1978).	
South Carolina	S.C. CODE ANN. § 38-71-760 (1988).	
South Dakota	NO ACTION TO DATE	
Tennessee	NO ACTION TO DATE	
Texas	TEX. INS. CODE ANN. art. 3.51-6A (1982) (Applies to group health insurance only).	
Utah	NO ACTION TO DATE	
Vermont	VT. STAT. ANN. tit. 8 §§ 4091a to 4091f (1989).	
Virgin Islands	NO ACTION TO DATE	
Virginia	NO ACTION TO DATE	
Washington	NO ACTION TO DATE	

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NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS/REGS.
West Virginia	NO ACTION TO DATE	
Wisconsin	WIS. ADMIN. CODE § INS. 6.51 (1982).	
Wyoming	WYO. STAT. §§ 26-19-201 to 26-19-204 (1989) (Replacement).	

Model Regulation Services--July 1994
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Legislative History
Cited to the proceedings of the NAIC

Section 1. Authority

It was a suggestion of the advisory committee that the insurance commissioner of most states have sufficient authority within the insurance statutes to affect resolution of the identified problems by means of appropriate administrative rules. **1972 Pro 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 **1972 Proc. II 483.**

Section 3. Definition

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

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 the 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.**

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Cited to the Proceeding of the NAIC

Section 5 (cont.)

Recommendations by the Task Force to Explore Problems Relating to Employer-Employee Group Coverages 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.**

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 does not have addresses of the insured. Requiring the employer to send notices for the insurer would also not be appropriate because the employer is not, under most jurisdictions' laws, an agent of the insurer. An employer unscrupulous enough to continue withholding employee contributions after termination of coverage is not likely to cooperate with the insurer in seeing that notice of such termination is 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 is the lower cost of the insurance to the policyholder and insured persons. The fact that the insurer deals with only one person, rather than with each member of the group separately, results in a lower cost to the insurer and the resulting savings are 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 such notification to the last address of each certificate holder as shown by the records of the policyholder. The task force decided to defer action on that suggestion. **1972 Proc. I 555-556, 608.**

The 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 is required for major medical and comprehensive medical coverage. For other hospital and medical coverage an extension of 90 days is required. **1972 Proc. II 482-483.**

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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.**

The industry advisory committee recommended that employers be protected again loss as a result of change in carriers. The prior carrier remains 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. Rules are established for the coverage of other persons covered by the prior carrier who are members of the class eligible for coverage under the succeeding carrier's plan. For such other persons a minimum level of benefits is required at the level of the prior carrier's plan, and coverage must be continued for certain minimum periods as specied. If the succeeding carrier's plan contin a preexisting condition exclusion, the insured nevertheless will 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 contains 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. The provisions will be of significant benefit to the public. **1972 Proc. II 483.**

Chronological Summary of Actions

June 1972: Model adopted.

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