02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 135: Employee Benefit Excess Insurance

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Section 1. Purpose

The purpose of this rule is to set forth standards for employee benefit excess insurance providing coverage for employers maintaining group health plans.

Section 2. Authority

The Superintendent adopts this rule pursuant to 24-A M.R.S. §§ 212 and 707(3).

Section 3. Scope

This rule applies to all insurers offering or renewing employee benefit excess insurance policies covering group health plans~~, and Multiple Employer Welfare Arrangements~~ in this State on or after the effective date of this rule. The Superintendent by written order may waive or modify some or all of the provisions of this rule, for good cause shown, for a policy offered to a retiree-only group health plan. If a policy provides coverage for a benefit plan that combines health benefits with other benefits such as death benefits or disability coverage, this rule applies to the coverage provided with respect to the plan's health benefits.

Section 4. Definitions

For purposes of this rule:

1. "Actuarial certification" means a written statement by a member in good standing of the American Academy of Actuaries, or other qualified individual acceptable to the Superintendent, that to the best of the actuary's knowledge and judgment, the insurer is in compliance with the applicable laws of the State of Maine and provisions of this rule, based upon an examination by the certifying individual and including a review of the appropriate records and the actuarial assumptions and methods used by the insurer in establishing attachment points and other applicable determinations.

2. "Attachment point" means the claims amount incurred by an insured group beyond which the insurer incurs a liability for payment.

3. "Eligible employee" has the same meaning as provided in 24-A M.R.S. §2808-B, subject to any applicable standards under the federal Affordable Care Act.

4. "Employee benefit excess insurance" means insurance protecting an employer against higher than expected obligations under an employee benefit plan, at retention levels that do not have the effect of making the plan an insured plan. Reinsurance provided to employers that self-insure their workers' compensation exposures pursuant to 39-A M.R.S. §403 does not constitute employee benefit excess insurance. The transaction of employee benefit excess insurance does not constitute the conduct of the business of reinsurance.

5. "Expected claims" means the amount of claims that, in the absence of an employee benefit excess insurance policy or other insurance, is projected to be incurred by an insured group through its health plan.

6. "Group health plan" has the same meaning as provided in Paragraph 2791(a)(1) of the federal Public Health Service Act, except that:

   A. A health benefit program offered by a multiple-employer welfare arrangement approved by the Superintendent under 24-A M.R.S. Chapter 81 is considered a group health plan, whether or not the program qualifies as a single group health plan under federal law, and the multiple-employer welfare arrangement shall be treated as the "employer" for purposes of this rule; and

   B. ~~but does not include a~~ A plan that provides only excepted benefits, as described in Subsection 2791(c) of the federal Public Health Service Act, is not considered a group health plan.

7. "Small employer" means an employer eligible for a small group health plan under 24-A M.R.S. §2808-B or under the federal Affordable Care Act.

8. "Tail coverage", also known as runout coverage or terminal liability option coverage, is a policy provision that covers claims incurred during a policy period, but paid after the policy terminates for a specific time period. This term includes policy provisions that function as described in this subsection regardless of the term used to describe the provision.

~~8. "Multiple Employer Welfare Arrangement" means a 24-A M.R.S. Chapter 81 approved Multiple Employer Welfare Arrangement.~~

Section 4. Employee Benefit Excess Insurance Standards

1. An employee benefit excess insurance policy may not:

A. Have an annual attachment point that is less than an amount set by the Superintendent for health benefit claims incurred per individual. The amount set by the Superintendent may differ based on the size of the group

B. Have an annual aggregate attachment point for health benefits that is less than 120 percent of expected claims, determined net of any specific excess coverage that might be provided by the policy, and verified by the insurer using reasonable and accepted actuarial principles;

C. Circumvent the minimum attachment point requirements of this subsection by mechanisms including, but not limited to:

(1) Calculating attachment points on a shorter basis than annual;
(2) Providing free or below-market financing for claims that have not yet reached the attachment point;

(3) Combining low aggregate attachment points with high specific attachment points, or with the omission of specific coverage; or

(4) Crediting claims other than medical claims toward the attachment point; or

~~C~~D. Provide direct coverage to individual plan participants or beneficiaries.

2. An insurer may not offer or renew an employee benefit excess insurance policy to a group~~,~~ with ten or fewer employees enrolled in the group health plan, ~~with the exception~~ except ~~of~~ that an insurer may renew an existing ~~a~~ policy that ~~was in force on the effective date of this rule, covering~~ covers a group with ten or fewer enrolled employees if that policy has been continuously in force prior to the original effective date of this rule. An insurer seeking to transfer a policy that meets this exception to an affiliate shall submit a request to the Superintendent, explaining the need for this transfer, at least two months before the policy's renewal date.

3. If the applicant or policyholder is a small employer~~, or a Multiple Employer Welfare Arrangement~~, the insurer may not offer or renew an employee benefit excess insurance policy that excludes or restricts coverage for claims made by any individual who is covered by the underlying benefit plan, or for claims arising out of any medical condition that is covered by the underlying benefit plan.

4. If an insurer offers or renews an employee benefit excess insurance policy that has an annual limit on coverage, or an exclusion applying to claims that are covered by the employer's benefit plan~~, or a Multiple Employer Welfare Arrangement~~, the insurer

must provide the employer with a disclosure notice explaining that the employer has unlimited responsibility for paying any claims that are above the annual limit of the excess insurance policy or are excluded from reimbursement by the excess policy.

5. Pursuant to 24-A M.R.S. §2452(1), an employee benefit excess insurance policy may not discriminate unfairly among or against beneficiaries of the underlying benefit plan, or treat conditions related to the Human Immunodeficiency Virus, or HIV, more restrictively than other sicknesses or disabling conditions.

6. Pursuant to 24-A M.R.S. §2849-B(7), an insurer may only offer or renew an employee benefit excess insurance policy when the underlying benefit plan~~, or Multiple Employer Welfare Arrangement~~, meets the requirements of continuity of coverage in Title 24-A, Chapter 36.

7. At the time an employee benefit excess insurance policy is issued or renewed, an insurer must make tail coverage available with a run-out period of at least six months after the end of the policy period, regardless of whether the coverage was renewed by the carrier or terminated by either the carrier or the insured. Tail coverage remains in force as the primary mechanism of coverage regardless of whether subsequent alterations in coverage on renewal include a provision to make the renewal terms applicable to a prior plan year or plan term. An insurer may issue or renew an employee benefit excess insurance policy that does not include tail coverage only if:

A. The employer requests that the policy does not include tail coverage;

B. The insurer provides the employer with a disclosure notice, approved by the Superintendent, advising the employer that the policy does not include tail coverage and explaining any risk associated with declining the coverage; and

C. The insurer obtains written acknowledgment from the employer that the employer declines tail coverage, and the acknowledgement is executed before the policy coverage period begins.

8. An insurer must pay the claims for which it is liable under an employee benefit excess insurance policy even if the employer~~, or Multiple Employer Welfare Arrangement,~~ is insolvent or otherwise fails to pay valid claims within the self-insured retention.

A. Notwithstanding paragraph 1(C) of this section, claims paid under this section shall be paid for the benefit of plan participants as directed by a bankruptcy trustee or court of competent jurisdiction or as agreed between the insurer and the plan's administrator or fiduciary.

B. This subsection does not require an insurer to drop down and pay claims within the self-insured retention.

C. This subsection does not prohibit the insurer from cancelling the policy for nonpayment of premiums or other good cause as permitted by law with timely advance notice, but cancellation does not extinguish the insurer's liability with respect to health care services provided before the effective date of the cancellation.

Section 4. Actuarial Certification

An insurer that has issued or renewed an employee benefit excess insurance policy subject to this rule at any time during a calendar year must file with the Superintendent on or before April 1st of the following year an actuarial certification in a form specified by the Superintendent, certifying that the insurer is in compliance with this rule. The insurer shall retain a copy of the certification at its principal place of business.

Section 4. Reporting

An insurer that has issued or renewed an employee benefit excess insurance policy in this State at any time during a calendar year must report the following information to the Superintendent about its excess insurance business in Maine, on or before April 1st of the following year, in an electronic format prescribed by the Superintendent. The insurer shall identify any information it considers to be a trade secret or otherwise protected from disclosure as a public record.

1. The total number of employers in Maine covered during the calendar year, broken down by small group and large group;

3. The number of eligible employees and the number of enrolled employees in each group; ~~and~~

4. The specific attachment point(s) for each group~~.~~;

5. The aggregate attachment point for each group, in dollars and as a percentage of expected claims; and

6. The aggregate claims paid out for each group.

Section 5. Severability

If any section, term, or provision of this rule shall be deemed invalid for any reason, any remaining section, term, or provision shall remain in full force and effect.

Section 6. Effective Date

The effective date of this rule is September 18, 2019.

STATUTORY AUTHORITY:
24 M.R.S. §§ 212, 707(3)

EFFECTIVE DATE:
September 18, 2019 – filing 2019-164

NON-SUBSTANTIVE CORRECTION:
August 12, 2021 – Section 5(7)(D) changed to 5(7)(B)