# 02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 280 GROUP HEALTH CONTRACTS CONVERSION RULE

1. Authority

This Rule is promulgated by the Superintendent pursuant to Title 24 M.R.S.A., Section 2330, Title 24-A M.R.S.A., Section 212 and Title 24-A M.R.S.A., Section 2809-A.

2. Purpose

The purpose of this Rule is to fulfill the requirements of Title 24 M.R.S.A., Section 2330 and Title 24-A M.R.S.A., Section 2809-A by establishing standards for benefits, rates and continuity of coverage with respect to health insurance conversion policies and certificates and certificates of non-profit hospital, medical, and health care service organizations.

3. Similar benefits

Conversion policies providing benefits set forth in this section will be deemed to be providing benefits similar to those provided by the group policy from which conversion is being made.

A. Insurers other than non-profit hospital, medical, and health care service organizations.

(1) Hospital Surgical Expense Benefits. If the group insurance policy from which conversion is made insures the employee or member, with or without dependent coverage, for basic hospital and/or surgical expense insurance; the covered individuals, pursuant to Title 24-A M.R.S.A., Section 2809-A, shall be entitled to obtain a converted policy, or at the insurer's option, a group certificate providing, at the individual's option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

PLAN A

(a) hospital room and board daily expense benefits in a dollar amount approximating or equal to the average semi-private rate charged in metropolitan areas of this State, for a period of seventy days per hospital confinement,

(b) miscellaneous hospital expense benefits in the amount of ten times the room and board daily expense benefits, per hospital confinement, and

(c) surgical expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum of eight hundred dollars, or

PLAN B

(a) hospital room and board daily expense benefits in a dollar amount equal to 75 percent of the dollar amount determined in Plan A, for a duration of seventy days per hospital confinement,

(b) miscellaneous hospital expense benefits in the amount of ten times the hospital room and board daily expense benefits, per hospital confinement, and

(c) surgical expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of six hundred dollars.

PLAN C

(a) hospital room and board daily expense benefits in a dollar amount equal to 50 percent of the dollar amount determined for Plan A, for a duration of seventy days per hospital confinement,

(b) miscellaneous hospital benefits in the amount of ten times the hospital room and board daily expense benefit, per hospital confinement, and

(c) surgical expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of four hundred dollars.

The dollar amount in Plan A, Subsection a, as of the effective date of this Rule is $200. This amount may be redetermined by the Superintendent from time to time, as to converted policies issued subsequent to such redetermination, but not more often than once in three years. The dollar amounts in Plans A, B and C shall be rounded upward to the nearest multiple of ten dollars ($10).

For the purpose of determining the hospital room and board daily expense benefits and the miscellaneous hospital expense benefits under Plans A, B, and C, the policy or certificate may define recurrent hospital confinements resulting from the same cause to be one continuous period of confinement if the confinements are separated by a period of less than 90 days. If recurrent hospital confinements do not result from the same cause or are separated by a period of 90 days or more, the subsequent confinement shall be considered to be a separate confinement for the purpose of determining the benefits payable under the policy or certificate.

(2) Major Medical Benefits. If the group insurance policy from which conversion is made insures the employee or member, with or without dependent coverage, for major medical expense insurance; the covered individuals, pursuant to Title 24-A M.R.S.A., Section 2809-A shall be entitled to obtain a converted policy or, at the insurer's option, a group certificate, providing major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, (i) or (ii) below:

(i) The smaller of the following amounts:

AA The maximum benefit provided under the group policy; or

BB A maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(ii) The smaller of the following amounts:

AA The maximum benefit provided under the group policy; or

BB A maximum payment of $250,000 for each unrelated injury or sickness.

(b) Payment of benefits at the rate of 80 percent of covered medical expenses which are in excess of the deductible, until 20 percent of such expenses in a benefit period reaches $1000, after which benefits will be paid at the rate of 100 percent during the remainder of such benefit period. If the group policy provided benefits for the outpatient treatment of mental illness, the converted policy shall provide a similar level of benefits for such treatment but need not exceed a level of 50 percent of covered expenses. If the group policy contained a maximum limitation on total mental health benefits, the converted policy may contain that same limitation.

(c) A deductible for each benefit period which, at the option of the insurer, shall be

(i) the sum of the benefits deductible and $100, or

(ii) the corresponding deductible in the group policy. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by: other hospital, surgical, or medical insurance policy; hospital or medical service subscriber contract; medical practice or other prepayment plan; or any other plan or program whether on an insured or uninsured basis; or in accordance with the requirements of any state or federal law; and, if pursuant to Subsection (f) of this Section the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits. If the maximum benefit is determined by (a) (ii) above, the insurer may require that the deductible be satisfied during a period of not less than three months, if the deductible is $100 or less; and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by (a) (i) above or twenty-four months when the maximum benefit is determined by (a) (ii) above.

(e) The term "covered medical expenses," as used above shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A or the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1200 maximum benefit.

(f) If the group insurance policy insures the employee or member for basic hospital and/or surgical expense insurance as well as major medical expense insurance, then, at the option of the insurer, the benefits outlined in subsections 1 and 2 above may be provided under one policy or certificate.

(3) Comprehensive Medical Expense Benefits.

(a) The insurer may also, in lieu of the plans of benefits set forth in subsections 1 and 2 above, provide a policy of Comprehensive Medical Expense Benefits without first dollar coverage. Said policy shall conform to the requirements of subsection 2 above, provided however, that an insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1000, and a third deductible option midway between the high and low deductible option.

B. Nonprofit Hospital, Medical and Health Care Service Organizations.

(1) If the group contract from which conversion is made provides the employee or member, with or without dependent coverage, hospital, medical, or health care benefits; the covered individuals, pursuant to Title 24 M.R.S.A., Section 2330, shall be entitled to obtain non-group coverage or, at the option of the nonprofit organization, a group certificate providing the same choice of coverage customarily being offered to non-group applicants. If no such non-group contracts are being issued, the converted coverage must be identical to the group coverage being terminated.

4. Continuity of coverage

A. The effective date of the converted policy shall be the moment of termination of coverage under the group policy.

B. The converted policy may exclude pre-existing conditions excluded by the group policy. However no provision of the converted policy shall deny benefits for a pre-existing condition that would have been covered by the group policy had group coverage remained in force. The converted policy may provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual insurance thereunder. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

5. Rates

The initial premium for the converted policy, whether group or individual, for the first twelve months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered and the type and amount of insurance provided. The experience under converted policies shall not be an acceptable basis for establishing rates for converted policies. However, if an insurer experiences incurred losses for a period of two years, or one year if earned premiums in that year exceed $100,000, on conversion policies which have been in force for at least one year, which exceed earned premiums by more than 20 percent, the insurer may file with the Superintendent of Insurance amended renewal rates for the subsequent year which will produce a loss ratio of not less than 120 percent.

6. General

A. Benefit Levels. If the benefit levels required in Section 3 above exceed the benefit levels provided under the group contract, the conversion policy or certificate may provide benefits which are at the level of those provided under the group contract in lieu of those benefits required in Section 3.

B. Alternate Plans. The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by this Rule. However no alternative plan may be offered unless the plans outlined in Section 3 are offered with equal emphasis.

C. Information Requested by Insurer. A converted policy or certificate may include a provision whereby the insurer may request information in advance of any premium due date of such policy or certificate of any person covered thereunder as to whether (i) he/she is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy; hospital or medical service contract; medical practice or other prepayment plan; or by any other plan or program, (ii) he/she is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or (iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

Failure of any covered person to respond to a request of the insurer made pursuant to this subsection may be deemed by the insurer to be a statement by the covered person that he or she is not covered for similar benefits by any other program, plan, policy, contract or other arrangement of coverage as to which the insurer requested information.

D. Group health insurance policies, by whatever name called, which are issued in connection with a "self-insured" or "self-funded" plan and which provide for the payment of benefits to employees or members under specified circumstances shall contain conversion provisions that are consistent with Title 24-A M.R.S.A., Section 2809-A and this Rule and which reflect the total coverage provided the employee or member.

7. Effective date

This Rule is effective October 18, 1982. This Rule does not apply to policies offered to persons becoming eligible to apply for a conversion policy on or after July 1, 1985.

NOTE: In the case of persons becoming eligible to apply for a conversion policy on or after July 1, 1985, refer to Maine Insurance Rule, Chapter 281.

History. -- Effective. 10-18-82.

History. -- Statutory Authority.--24 M.R.S.A.

§ 2330; 24-A M.R.S.A. §§ 242 and 2809A.

EFFECTIVE DATE (ELECTRONIC CONVERSION): January 14, 1997

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025