BULLETIN

Re: MARYLAND CONTINUATION COVERAGE
Maintaining group health insurance benefits after leaving the group

Date: October 1, 2002

Bulletin: Life and Health 02-20

This Bulletin replaces Life and Health Bulletin 00-15, regarding Maryland Continuation Coverage. The only change from the prior Bulletin is found in the ***Termination of Employment*** *section of this Bulletin.*

Most people are familiar with the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), which requires issuers of health insurance coverage to continue to offer to individuals who leave an employer group the same terms of coverage that it issues to the group. Maryland also has laws requiring insurers, nonprofit health service plans, and health maintenance organizations (HMO's) to offer continuation coverage to individuals who lose group membership through three events: involuntary termination of employment, death, or divorce.

While Maryland's continuation laws and COBRA have many similarities, there are some important differences. A comparison chart is attached to this bulletin. When either state or federal law could be applied, an individual need not make an election of one or the other. Rather, the Administration has taken the position that Maryland consumers who qualify for either state or federal law are entitled to choose both, and if there are differences in qualifications or benefits, those differences are to be resolved in favor of the consumer. There are some situations for which continuation coverage may only be available under COBRA, and other situations for which continuation may only be available under Maryland law. For example, only Maryland's law requires continuation coverage for an individual whose employer group has fewer than 20 employees.

An individual must meet the requirements to qualify for continuation coverage. Different requirements apply to each event that results in loss of group membership. Under all continuation laws, the person continuing coverage must pay the full amount of the premium, including the portion formerly paid by the employer. There may also be an administrative fee added to the premium.

Continuation coverage is always made available without evidence of insurability. Usually a form is filed with the employer indicating that the person is eligible to, and wants to, continue coverage. The effective date of coverage is the date of the event that causes loss of group membership. The benefits provided are the same as those provided to other members of the group. Coverage terminates after a fixed period of time or on the occurrence of a subsequent event. Failure to make timely payments for coverage also would result in its termination.

An individual who does not qualify for continuation coverage may be able to obtain a conversion policy. However, a conversion policy will typically have higher premiums and fewer benefits than continuation coverage. Alternatively, the individual may be eligible for individual coverage, issued without medical underwriting and with no preexisting condition limitations, under the Health Insurance Portability and Accountability Act (HIPAA).

Individuals who have health insurance through group membership and who may lose group membership through termination of employment, death, or divorce, should read the provisions governing continuation that are part of the contract between the group policyholder (the employer) and the issuer of the health insurance coverage, as well as Maryland law and regulations, in their entirety. Text of the law is available at www.mlis.state.md.us. Text of the regulations is available through the home page of the Maryland Secretary of State, Division of State Documents at www.dsd.state.md.us .

Following is a summary of important provisions related to each event that results in loss of group membership.

Termination of Employment
§15-409 of the Insurance Article
COMAR 31.11.04

Maryland law requires continuation coverage be offered to an employee who voluntarily terminates employment or whose employment is involuntarily terminated other than for cause. To qualify for continuation coverage under Maryland law, an individual must be a resident of Maryland who had health insurance coverage under a group contract with the same employer for at least three months before the termination.

The individual must submit a signed election for continuation coverage within the 45-day period following the date of termination of employment. An administrative fee of up to 2% of the total premium may be added to the cost of coverage. The individual pays the premium each month to the employer.

Continuation coverage ends after 18 months, or earlier for any of the following reasons:

- For not making payments on time

- If the individual becomes eligible for coverage under another group expense-incurred medical insurance policy or HMO
- If the individual becomes entitled to benefits under Medicare
- If the individual becomes covered under a non-group expense-incurred medical insurance policy or HMO
- If the individual terminates the coverage
- If the employer no longer offers any group health benefit plan.

Death of a Covered Employee
§15-407 of the Insurance Article
COMAR 31.11.03

Maryland law requires continuation coverage be offered to the surviving spouse and dependent children (qualified secondary beneficiary) of an employee who dies. The employee must have been a resident of Maryland who had health insurance coverage under a group contract with the same employer for at least three months before death. Additionally, coverage must be offered to a child of the employee who is born to the surviving spouse after the employee's death.

The qualified secondary beneficiary or authorized representative must submit a signed election for continuation coverage within the 45-day period following the date of the employee's death. An administrative fee of up to 2% of the total premium may be added to the cost of coverage. The qualified secondary beneficiary pays the premium each month to the employer.

For a dependent child of the deceased employee, continuation coverage ends on the date on which the child would no longer be covered under the group contract if the employee had not died.

For a surviving spouse, continuation coverage ends after 18 months.

For an individual who is either a dependent child or surviving spouse, continuation coverage ends earlier than described above for any of the following reasons:

- For not making payments on time
- If the individual becomes eligible for coverage under another group expense-incurred medical insurance policy or HMO
- If the individual becomes entitled to benefits under Medicare
- If the individual becomes covered under a non-group expense-incurred medical insurance policy or HMO
- If the individual terminates the coverage
- If the employer no longer offers any group health benefit plan.

Divorce
§15-408 of the Insurance Article
COMAR 31.11.02

Maryland law requires continuation coverage be offered to the former spouse and dependent children (qualified secondary beneficiary) of an employee after a divorce. Additionally, coverage must be offered to a child of the employee who is born to the former spouse after the divorce. Divorced spouses and dependent children are entitled to continuation coverage only while the employee is covered by a group contract.

Notice of the divorce must be given to the employer. If the employee later obtains group coverage through a different employer, a notice must be given to that employer in order to maintain continuation coverage. The costs of the continuation coverage are paid by the employee, who may be reimbursed for all or part of the extra expense by the former spouse, by agreement of the parties or by court order.

For a dependent child of the employee, continuation coverage ends on the date on which the child would no longer be covered under the group contract if the divorce had not occurred. Otherwise, coverage may be terminated for any of the following reasons:

- For the former spouse, on remarriage
- For not making payments on time
- For a qualified secondary beneficiary, on becoming eligible for coverage under another group expense-incurred medical insurance policy or HMO
- For a qualified secondary beneficiary, on becoming entitled to benefits under Medicare
- For a qualified secondary beneficiary, on becoming covered under a non-group expense-incurred medical insurance policy or HMO
- On termination of the coverage by the qualified beneficiary
- If the employer no longer offers any group health benefit plan.

Additional information on how to obtain continuation coverage may be found in the Certificate of Coverage issued by the insurance company or HMO.

Six-Month Continuation
(Not applicable to HMOs or to small group contracts)
COMAR 31.11.10.14

A regulation adopted by the Maryland Insurance Administration before federal COBRA was enacted still exists to provide continuation coverage of a very limited scope. The regulation requires continuation coverage for a six-month period to be offered to an individual who has been covered for at least 3 months under a group policy, and who loses that coverage for any reason except the following: the individual became eligible for Medicare, reached a limiting age specified in the policy, or failed to pay a required premium or contribution.

Health maintenance organizations are not subject to the regulation. Also, another regulation, which establishes the benefits for the Comprehensive Standard Health Benefit Plan for small employer groups in Maryland (up to 50 eligible employees), excludes 6-month continuation coverage for all small employer groups, even if the group coverage is issued by a nonprofit health service plan or an insurer. Therefore, *an individual may not obtain six-month continuation coverage if the individual's group coverage is regulated under the small employer group market, or is issued by a health maintenance organization.*

An individual who obtains the six-month continuation coverage must pay the monthly premiums to the employer. If the employer terminates the group policy or refuses to send the premiums to the insurance company due to a labor dispute, the individual may pay the insurer directly. In that case, the insurer may charge an administrative fee of up to 20% of the premium.

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Howard Max
Acting Associate Commissioner
Life and Health