House Legislative Analysis Section

Manufacturer's Bank Building, 12th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

HMO SUPPLEMENTAL CONTRACTS

House Bill 4185 as enrolled
Sponsor: Rep. Lloyd F. Weeks

House Committee: Insurance
Senate Committee: Commerce & Technology
Second Analysis (1-11-91)

THE APPARENT PROBLEM:

Earlier this session, the legislature made changes in the Insurance Code's regulations covering Medicare supplemental insurance policies, in part to take into account passage at the federal level of the Medicare Catastrophic Coverage Act of 1988, which expanded the federal Medicare health insurance program. Congress repealed the act in 1989, however, in response to angry opposition by intended beneficiaries to the method of financing the expansion. This means that state laws governing Medicare supplemental policies must once again be altered so as to conform to federal law. At the same time, insurance specialists say, the federal government is requiring states to adopt certain Medicare supplemental marketing standards developed by the National Association of Insurance Commissioners aimed at preventing abuses in the sale of such policies to older Americans. Senate Bill 389 amended the Insurance Code to add these changes. At the same time, insurance regulators have recommended that health maintenance organizations be subject to the same regulations because they are beginning to offer Medicare supplemental contracts similar to those offered by insurance companies and Blue Cross and Blue Shield of Michigan.

THE CONTENT OF THE BILL:

The bill would amend the Public Health Code to apply to health maintenance organizations (HMOs) the same regulations for Medicare supplemental contracts that apply to insurance companies and Blue Cross and Blue Shield of Michigan. The bill would reflect the changes being made to Medicare supplemental regulations generally, mostly as a result of recent federal legislation.

The outline of coverage that must be provided to all applicants for a supplemental policy, which explains benefit gaps in Medicare, would be revised to reflect changes in the federal Medicare program resulting from the repeal of the Medicare Catastrophic Coverage Act of 1988.

New federally-required marketing standards (reportedly drafted by the National Association of Insurance Commissioners) would be adopted. These provisions, among other things, require the fair and accurate comparison of policies for customers, require that any existing coverage be identified before new coverage is sold, prohibit the sale of excessive and duplicative coverage, and require that when one supplemental policy replaces another, the new policy waive all waiting periods and similar restrictions. A form notifying applicants for replacement coverage of their protections and advising them on how to evaluate their coverage would be mandated. The standards also specifically prohibit "twisting" (convincing a person to switch from one policy to another by misrepresentation), high pressure tactics, and cold lead advertising (a method of marketing that fails to disclose that its purpose is to sell insurance and that contact will later be made by an agent or company). Advertisements for supplemental policies would have to be filed with the Insurance Bureau at least 45 days before use.

MCL 333.1101 et al.

FISCAL IMPLICATIONS:

The Insurance Bureau reports that the bill has no revenue or budgetary implications. (1-6-90)

ARGUMENTS:

For:

The bill would apply to HMOs the kind of Medicare supplemental regulations that are applied to other providers of that coverage and makes changes to those regulations required by recent actions at the federal level. The changes reflect the recent repeal of the 1988 expansion of Medicare to cover certain "catastrophic" expenses by modifying the outline of coverage that must be provided to policy applicants, and reflect the requirement that Medicare supplemental marketing standards of the National Association of Insurance Commissioners (NAIC) be adopted by the states. Insurance regulators note that until recently HMOs provided Medicare supplemental coverage only through risk contracts with the federal Health Care Financing Administration, but have lately begun to issue supplemental contracts similar to those offered by insurance companies and Blue Cross-Blue Shield. They must be similarly regulated.

Against:

Insurance regulators have recommended that health maintenance organizations (HMOs) be required to offer Medicare supplemental coverage to their customers when those customers become eligible for Medicare. Commercial insurance companies and Blue Cross-Blue Shield are required to offer this coverage but HMOs are not. This does not appear to be equal treatment. While some HMOs offer this coverage, others do not. A person insured through an HMO that does not offer Medicare supplemental contracts must seek coverage elsewhere upon becoming eligible for Medicare, which may mean changing physicians and other providers and facing waiting periods for treatment of some conditions to be covered. HMOs would be free to charge an appropriate price for such coverage so there would not appear to be any financial risk.