SFA BILL ANALYSIS

Senate Fiscal Agency • Lansing, Michigan 48909 • (517) 373-5383

House Bill 4185 (Substitute H-3 as reported without amendment)
Sponsor: Representative Lloyd F. Weeks
House Committee: Insurance
Senate Committee: Commerce and Technology

Date Completed: 5-3-90

RATIONALE

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 of the Federal Medicare Catastrophic Coverage Act of 1988, which expanded the Federal Medicare health insurance program. Congress repealed the Act in 1989, however, apparently in response to angry opposition by intended beneficiaries to the method of financing the expansion. This means that State laws governing Medicare supplemental policies once again do not 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.

CONTENT

The bill would amend the Public Health Code to provide for the regulation of Medicare supplemental contracts issued by health maintenance organizations (HMOs). Specifically, the bill would:

- **Prescribe certain standards for Medicare supplemental policies, including the minimum amount of coverage that would have to be included.**
- **Specify the eligibility criteria for such contracts.**
- **Prohibit certain marketing and selling techniques and require that fair and accurate marketing procedures be adopted.**
- **Detail the procedures by which HMOs would notify subscribers of any changes in their Medicare supplemental contracts.**
- **Specify the procedures for determining the rate for individual Medicare supplemental contracts and for filing rate adjustments.**
- **Prescribe procedures by which HMO enrollees could convert to a Medicare supplemental contract.**

"Medicare supplemental contract" would mean a group or individual contract that was advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. A Medicare supplemental contract would not include a Medicare supplemental contract of one or more employers or labor organizations, or the trustees of a fund established by one or more employers or labor organizations, for the employees, former employees, members, or former members of the labor organizations.

A more detailed explanation of the bill follows.

Content of Policies

Specifically, the bill would require each HMO or group health maintenance contract holder offering coverage in Michigan to give written notice of the availability of Medicare supplemental coverage to each person or subscriber who was covered at the time he or

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she became eligible for Medicare, and to each applicant who was eligible for Medicare. Further, the bill would require an HMO to provide:

- -- A Medicare supplemental buyer's guide to each applicant for a Medicare supplemental contract.
- -- An outline of coverage to each prospective individual subscriber before application. The bill specifies what would have to be included in the outline.
- -- A form notifying applicants of replacement of their Medicare supplemental coverage and advising them on how to evaluate their coverage.

At a minimum, Medicare supplemental contracts would have to meet the requirements of a Type I or Type II Medicare supplemental package. These requirements, however, would not preclude the inclusion of other provisions or benefits that were not inconsistent with the provisions of the packages. A Type I package would have to cover, at a minimum, the deductible and copayment requirements of Part A and Part B of the Federal Medicare Program and coverage of 90% of Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days. A Type II package would have to provide the same coverage as a Type I package but would have to exclude coverage for the Part A and Part B dollar deductibles, other than deductibles for blood, with an appropriate reduction in rate.

In addition, the contract would have to meet the following standards, which would not preclude the inclusion of other provisions or benefits that were not inconsistent with the standards:

- -- The contract could not exclude coverage for more than six months from the effective date of coverage for a preexisting condition. The contract could not define a preexisting condition more restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
- -- The contract could not provide benefits for services needed due to sickness on a different basis than services needed due to accidents.
- -- The contract would have to provide that benefits designed to cover cost sharing amounts under Medicare would be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Rates could be modified to correspond with the changes with the Insurance Commissioner's approval.
- -- The contract would have to be guaranteed renewable. Termination could be only as permitted in the contract and approved by the Insurance Commissioner or as permitted by law. Medicare supplemental contracts would have to include a renewal provision appropriately captioned and clearly stating the term of coverage for which the contract was issued and for which it could be renewed.
- -- Termination of a contract could not reduce or limit the payment of benefits for any continuous services that commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force could be predicated upon the continuous total disability of the enrollee, limited to the duration of the contract benefit period, if any, or payment of the maximum benefits.

Except for emergency care and specified benefits for services provided outside of an HMO's service area, a Medicare supplemental contract would have to require that benefits be available only if services were provided or authorized by the HMO's employed or affiliated providers in accordance with the HMO's procedures.

If a Medicare supplemental contract replaced another Medicare supplemental policy, certificate or contract, the replacing HMO would have to waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplemental contract for similar benefits to the extent such time was spent under the original coverage.

A contract could not use waivers, riders, or any other contract provisions to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. If a contract contained any limitations concerning preexisting conditions, the limitations would have to appear as a separate paragraph of the contract and be labeled "preexisting condition limitations".

Marketing Practices/Duplicative Policies

Each HMO would be required to do all of the following:

-- Establish marketing procedures to ensure that any comparison of contracts by its health benefit agents or enrollment agents would be fair and accurate, and that excessive coverage would not be sold or issued.
-- Make every reasonable effort to determine whether a prospective applicant for Medicare supplemental coverage already had disability or other health coverage and to identify the types and amounts of any such coverage.
-- Establish auditable procedures for verifying compliance with these requirements.

The bill also would 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). Further, the bill would require advertisements for supplemental policies to be filed with the Insurance Bureau at least 45 days before use.

Medicare supplemental contracts could not provide benefits that duplicated those provided by Medicare.

Health benefit agents or enrollment representatives would be required to make reasonable efforts to determine the appropriateness of recommending the purchase or replacement of any Medicare supplemental coverage. Any sale of Medicare supplemental coverage that would provide an individual with more than one Medicare supplemental policy, certificate, or contract would be prohibited.

Application forms for individual Medicare supplemental contracts would have to include questions as specified in the bill that were designed to elicit information as to whether the applicant had another Medicare supplemental policy, contract, or certificate in force or whether a Medicare supplemental contract was intended to replace any disability or other health policy, certificate or contract presently in force.

A health benefit agent or enrollee representative would have to list on the application form for a supplemental contract any other HMO contracts he or she had sold to the applicant, including contracts still in force and those sold in the past five years that were no longer in force.

On or before March 1 of each year, every HMO providing Medicare supplemental coverage in Michigan would have to report to the Insurance Commissioner the contract number and date of issuance for every individual resident of the State for which the HMO had in force more than one Medicare supplemental contract.

A HMO would be prohibited from compensating an agent or employee for the sale or service of a contract issued to a person eligible for Medicare unless the amount of the compensation paid in the first year did not exceed the amount of the compensation the agent or employee received for the contract in each of the two subsequent consecutive annual renewal periods.

Eligibility for Contracts

A Medicare supplemental contract could not be issued to a person who had not applied for or enrolled in Part A or Part B of the Federal Medicare Program. If it were determined later that the person had not applied for the Federal program, the HMO would be required to refund all contract payments received from that person for the supplemental contract plus interest minus the amount of any benefits the person received under the contract. The interest would be calculated at six-month intervals from the date the first contract payment was received at a rate of interest equal to 1% plus the average interest rate paid at auctions of

five-year U.S. Treasury notes during the six months immediately preceding July 1 and January 1, as certified by the State Treasurer, and compounded annually.

Rates and Rate Adjustments

The rate for an individual Medicare supplemental contract would have to be determined by using the aggregate experience of actual and expected losses for all such contracts issued in each service area or in aggregate service areas by the HMO. Each HMO that issued Medicare supplemental contracts would have to comply with Federal regulations and certify that compliance on the Medicare supplement insurance experience reporting form.

As soon as practicable but no later than 45 days after the effective date of any Medicare benefit changes, a HMO providing Medicare supplemental contracts in the State would have to file with the Insurance Commissioner any appropriate rate adjustments and any supporting documents necessary to justify the adjustments and any appropriate forms needed to modify the Medicare supplemental contract to adjust benefits or eliminate duplicative benefits. The form would have to provide a clear description of the benefits provided by the contract. After satisfying the filing and approval requirements, the HMO would have to provide to each subscriber any form necessary to eliminate benefits under the contract that duplicated benefits provided by Medicare.

Notification of Policy Changes

As soon as practicable but no later than 30 days before the annual effective date of any Medicare benefit changes, the HMO would have to notify each subscriber of modifications made to its Medicare supplemental contract. The notice would have to be in outline form, contain clear and simple language, and include a description of revisions to the Medicare program and each modification to the coverage provided under the supplemental contract. The notice could not be accompanied by any solicitation.

Conversion

The bill would require an HMO that offered Medicare supplemental coverage to provide without restriction to a permanent resident of the HMO's service area who requested coverage from the HMO and who was enrolled under an HMO contract issued by the HMO a right of conversion to a guaranteed renewable or noncancelable Medicare supplemental contract that at a minimum was a Type I or II Medicare supplemental package, if that person would no longer be covered because he or she had become eligible for Medicare or if that person lost coverage under a group contract after becoming eligible for Medicare. An HMO that did not offer a Medicare supplemental contract or alternative Medicare coverage under contract with the Federal government would have to include notice of that fact on its enrollment forms.

The bill specifies that a person who was hospitalized or had been informed by a physician that he or she would require hospitalization within 30 days after applying for coverage would not be entitled to coverage under the Medicare supplemental contract until the day following the date of discharge. If, however, the person were covered by the HMO immediately prior to becoming eligible for Medicare or immediately prior to losing coverage under a group contract after becoming eligible for Medicare, the person would be eligible for immediate coverage.

A person wishing coverage would have to request such coverage either within 90 days before or 90 days after the month he or she became eligible for Medicare or within 180 days after losing coverage under a group contract. A person 60 years of age or older who lost coverage under a group contract would be entitled to coverage under a Medicare supplemental contract without restriction, other than residency, from the organization that provided the former group coverage, if he or she requested coverage within 90 days before or after the month he or she became eligible for Medicare.

Generally, a person who was not covered under an individual or group health maintenance contract prior to applying for a Medicare supplemental contract could be offered a Medicare supplemental contract that included a provision for exclusion of preexisting conditions for six months after the effective

date of coverage.

Proposed MCL 333.21054c-333.20154t

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

ARGUMENTS

Supporting Argument

The bill would put into State statute regulations for Medicare supplemental policies required by the Federal government. The bill reflects 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. Further, it would bring Michigan into compliance with the Federal requirement that Medicare supplemental marketing standards of the National Association of Insurance Commissioners (NAIC) be adopted by the states.

Even without the Federal impetus, however, the bill is an important piece of regulatory legislation. Insurance regulators note that until recently HMOs provided Medicare supplemental coverage only through risk contracts with the Federal Health Care Financing Administration, but lately have begun to issue supplemental contracts similar to those offered by insurance companies and Blue Cross-Blue Shield. Therefore, they argue, for the protection of the consumer, HMO Medicare supplemental contracts should be similarly regulated.

Opposing Argument

The bill does not do enough to protect elderly consumers because it would not mandate that HMOs 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 for the insurers. 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. Since HMOs would be free to charge an appropriate price for such coverage, there would not appear to be any financial risk to them, even if Medicare supplemental coverage were mandated.

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