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SFA BILL ANALYSIS

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Senate Bills 748 and 749 (as enrolled) **PUBLIC ACTS 304 & 559 of 2002**
Sponsor: Senator Bev Hammerstrom (S.B. 748)
Senator Bill Bullard, Jr. (S.B. 749)
Senate Committee: Health Policy
House Committee: Insurance and Financial Services

Date Completed: 3-10-03

CONTENT

Senate Bill 748 amended Chapter 38 of the Insurance Code, and Senate Bill 749 amended Part 4A of the Nonprofit Health Care Corporation Reform Act, to revise the provisions in both the Code and the Act that regulate Medicare supplement policies and Medicare supplement certificates, respectively. (The provisions of Chapter 38 and Part 4A that regulate Medicare supplement policies and certificates are nearly identical in content.) The amendments to Chapter 38 and Part 4A do the following:

-- Provide for the sale of high deductible plans.
-- Add provisions to regulate Medicare+Choice plans (which already were allowed under Federal Medicare regulations).
-- Allow a policyholder to suspend a Medicare supplement policy, and have the policy reinstated, under certain circumstances.
-- Specify conditions under which an applicant for a Medicare supplement policy may not be excluded from coverage because of a preexisting condition.
-- Specify individuals who are eligible for coverage, and prescribe conditions under which people may not be denied coverage.
-- Establish time periods during which eligible individuals must be allowed to enroll.
-- Require notification when a plan is terminated.

Additionally, Senate Bill 748 amended Part 2 of the Code to require the Department of Community Health (DCH), until October 1, 2003, to assess a quality assurance fee on each health maintenance organization (HMO) that has a Medicaid managed care contract awarded by the State and administered by the DCH, in order to increase the Medicaid reimbursement rate; and appropriate revenue to the DCH for fiscal year (FY) 2002-03. The bill also amended Part 35 of the Code to allow HMOs to have health care contracts with deductibles.

Senate Bill 749 amended Part 2 of the Nonprofit Health Care Corporation Reform Act to prohibit a nonprofit health care corporation (Blue Cross and Blue Shield of Michigan, or BCBSM) from changing its nonprofit status, or from dissolving, merging, consolidating, mutualizing, or taking any other action that results in a change of direct or indirect control of BCBSM.

The bills also repealed sections of the Code and the Act that required an insurer and BCBSM to report each year to the Commissioner of the Office of Financial and Insurance Services, the policy and certificate number and date of issuance for every individual in the State for whom the insurer had more than one Medicare supplement policy or certificate in force (MCL 500.3837 & 550.1487). Also, Senate Bill 749 repealed sections of the Act that permitted the merger or consolidation of nonprofit health care corporations, and provided for BCBSM's assets to escheat to the State upon dissolution (MCL 550.1216 & 550.1217).

Senate Bill 748 took effect on May 10, 2002, and Senate Bill 749 took effect on September 27, 2002.

High Deductible Plans

Chapter 38 and Part 4A allow an insurer and BCBSM to offer various Medicare supplement plans, known as Plans A through J, and prescribe the coverages of each plan, including the medical services and care offered, and the amounts Medicare pays, the supplemental plan pays, and the insured pays. These amounts are determined by Federal regulations. The bills changed the amounts in the various plans to reflect changes that have occurred in Federal regulations.

Each plan prescribes the core benefits that must be included, and limits other coverages as specified. The bills amended Plan F and Plan J to allow for a standardized Medicare supplement high deductible plan, which includes only 100% of covered expenses following payment of the annual high deductible. The annual high deductible is $1,580 for 2001, and must be adjusted for inflation each year thereafter. The covered expenses include the core benefits, plus Medicare deductibles and excess charges, and medically necessary emergency care in a foreign country. Under Plan J, covered expenses also include an extended outpatient prescription drug benefit, a preventative medical care benefit, and an at-home recovery benefit. The annual high deductible under both Plans F and J consists of out-of-pocket expenses (other than premiums) for services covered by the plans, and is in addition to any other specific benefit deductibles.

Suspension of Policy

The bills require each Medicare supplement policy to provide that benefits and premiums under the policy must be suspended at the request of the policyholder when he or she is entitled to benefits under Section 226(b) of Title II of the Social Security Act, and covered under a group health plan, as defined in Section 1862(b)(1)(a)(v) of the Social Security Act. If suspension occurs and if the policyholder loses coverage under the group health plan, the policy must be automatically reinstituted effective on the date of loss of coverage, if the policyholder provides notice of the loss within 90 days after the loss and pays the premium attributable to the time period. (Section 226(b) of Title II contains criteria for entitlement to hospital insurance benefits for individuals under age 65. Section 1862(b)(i)(a)(v) defines "group health plan" with reference to a definition in the Internal Revenue Code, i.e., a plan of, or contributed to by, an employer or employee organization to provide health care to the employees, former employees, the employer, or others associated with the employer in a business relationship, or their families.)

Preexisting Condition Exclusion

Under Chapter 38 and Part 4A, an insurer and BCBSM may not deny or condition the issuance or effectiveness of a Medicare supplement policy, or discriminate in the pricing of the policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant, if an application for the policy is submitted during the six-month period beginning with the first month in which an individual who is 65 years old or older first enrolled for benefits under Medicare. The bills further provide that an insurer and BCBSM may not exclude benefits based on a preexisting condition if an applicant qualifies under the existing provisions; submits an application within the time required under those provisions; and as of the date of application has had a "continuous period of creditable coverage" of at least six months. If the applicant meets these conditions but has had a continuous period of creditable coverage of less than six months, the insurer or BCBSM must reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary of the U.S. Department of Health and Human Services (HHS) must specify the manner of the reduction.

The bills state that, except for the preexisting condition restrictions in the bills, and provisions in Section 3833 of Chapter 38 or Section 483 of Part 4A, the existing provisions do not prevent the exclusion of benefits under a policy during the first six months based on a preexisting condition for which the policyholder received treatment or was otherwise diagnosed during the six months before the coverage became effective. (Under Sections 3833 and 483, if a Medicare supplement policy replaces another Medicare supplement policy, certificate, or contract, the replacing insurer must waive any time periods

applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits, to the extent such time was spent under the original coverage.)

Under the bills, "continuous period of creditable coverage" means the period during which an individual was covered by "creditable coverage", if during the period of the coverage the individual had no breaks in coverage over 63 days. "Creditable coverage" means coverage of an individual provided under a group health plan; health insurance coverage; Part A of Medicare (hospital benefits for the aged and disabled); Part B of Medicare (supplementary medical insurance benefits for the aged and disabled); Medicaid other than coverage consisting solely of benefits under Section 1928 of Medicaid (which provides for a pediatric vaccine distribution program); Chapter 55 of Title 10 of the United States Code (which provides for medical and dental care for members, and certain former members, of the armed forces); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 of the United States Code (which provides for health insurance for certain Federal employees and officials); a public health plan as defined in Federal regulation; and health care provided under the Peace Corps Act.

Creditable coverage does not include any of the following:

-- Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; or other similar insurance coverage, specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
-- The following benefits, if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those types of care; or other similar, limited benefits as specified in Federal regulations.
-- The following benefits if offered as independent, noncoordinated benefits: coverage only for a specified disease or illness; hospital indemnity; or other fixed indemnity insurance.
-- The following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental policy as defined under Section 1882(g)(1) of Part D of Medicare; coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the U.S. Code (described above); and similar supplemental coverage provided under a group health plan.

(Section 1882(g)(i) defines "medicare supplemental policy" as a health insurance policy or other health benefit plan offered by a private entity to individuals entitled to Medicare, that provides reimbursement for expenses incurred for services and items for which payment may be made under Medicare but that are not reimbursable due to deductibles, coinsurance amounts, or other limitations imposed by the Medicare law, subject to certain exceptions for Medicare+Choice plans and other policies or plans established by employers or labor organizations.)

Eligible Persons

The bills prescribe several criteria that a person may meet to be considered eligible for a Medicare supplement policy, and the "guaranteed issue time periods" during which certain individuals may be eligible. An eligible person is an individual who meets the criteria and submits evidence of the date of termination or disenrollment with the application for a Medicare supplement policy. For an eligible person, an insurer may not deny or condition the issuance or effectiveness of a Medicare supplement policy (described below) that is offered and is available for issuance to new enrollees by the insurer; may not discriminate in the pricing of the Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and may not impose an exclusion of benefits based on a preexisting condition under the Medicare supplement policy.

One type of eligible person is an individual who is enrolled under an employee welfare

benefit plan that provides health benefits supplementing the benefits under Medicare, and that terminates or ceases to provide all those supplemental health benefits to the individual. The individual is entitled to a policy that has a benefit package classified as Plan A, B, C, or F, offered by any insurer; and the guaranteed issue time period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and ends 63 days after the date of the applicable notice.

An eligible person also is an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances applies; or the individual is 65 years old or older and is enrolled with a PACE provider under Section 1894 of the Social Security Act (which governs Programs of All-Inclusive Care for the Elderly), and there are circumstances similar to the following that would permit discontinuance of his or her enrollment with the provider if the individual were enrolled in a Medicare+Choice plan:

-- The certification of the organization or plan has been terminated.
-- The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.
-- The individual is no longer eligible to elect the plan because of a change in his or her place of residence or other change in circumstances specified by the Secretary of HHS, but not including termination of the individual's enrollment on the basis of Section 1851(g)(3)(b) in the Social Security Act (disruptive behavior); where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards established under that Act; or the plan is terminated for all individuals within a residence area.
-- The individual demonstrates, in accordance with guidelines established by the Secretary, that the organization offering the plan substantially violated a material provision of its contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide covered care in accordance with applicable quality standards; or the organization, or agent or other entity acting on its behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.
-- The individual meets other exceptional conditions as the Secretary provides.

Under these provisions, the individual is entitled to a policy that has a benefit package classified as Plan A, B, C, or F, offered by any insurer. For an individual eligible under these provisions whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that he or she receives a notice of termination and ends 63 days after the date the applicable coverage is terminated. For an individual who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends 63 days after the effective date.

Further, an eligible person is an individual who is enrolled with an eligible organization under a contract under Section 1876 of the Social Security Act; a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; an organization under an agreement under Section 1833(a)(1)(a) of the Social Security Act; a health care prepayment plan; or an organization under a Medicare select policy. (Section 1876 governs payments to HMOs and competitive medical plans, and provides for a per capita rate of payment for classes of individuals enrolled with an eligible organization that has entered into a risk-sharing contract. Section 1833(a)(1)(a) refers to organizations that provide medical and other health services on a prepayment basis.) These provisions apply to an enrollment that ceases under the same circumstances that permit discontinuance of an individual's election of coverage with a Medicare+Choice organization or PACE provider, as described above. Under these provisions, the individual is entitled to a policy that has a benefit package classified as Plan A, B, C, or F, offered by any insurer. For an individual eligible under these provisions whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that he or she receives a notice of termination and ends 63 days after the date the applicable coverage is terminated. For an

individual who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends 63 days after the effective date.

In addition, an eligible person is an individual who is enrolled under a Medicare supplement policy and the enrollment ceases because of any of the following: the insolvency of the insurer or bankruptcy of the noninsurer organization, or other involuntary termination of coverage or enrollment under the policy; the insurer substantially violated a material provision of the policy; or the insurer, or an agent or other entity acting on its behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. The individual is entitled to a policy that has a benefit package classified as Plan A, B, C, or F, offered by any insurer. If the individual's enrollment ceases because of the insolvency of the insurer, bankruptcy of a noninsurer organization, or other involuntary termination, the guaranteed issue time period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice, if any, or the date that the applicable coverage was terminated, and ends 63 days after the date the coverage is terminated. For an individual who disenrolls voluntarily because of the insurer's violation or misrepresentation, the guaranteed issue time period begins 60 days before the effective date of the disenrollment and ends 63 days after the effective date.

An eligible person also is an individual who was enrolled under a Medicare supplement policy, terminates enrollment, and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan, any eligible organization under a contract under Section 1876 of the Social Security Act, Medicare cost, any similar organization operating under demonstration project authority, any PACE provider, or a Medicare select policy. This provision applies if the enrollee terminates the subsequent enrollment during any period within the first 12 months of the subsequent enrollment during which he or she is permitted to terminate the subsequent enrollment under Section 1851(e) of the Social Security Act (which governs coverage election periods for Medicare+Choice). The Medicare supplement policy to which the person is entitled is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not available, a policy that has a benefit package classified as Plan A, B, C, or F, offered by any insurer. For an eligible individual whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that he or she receives a notice of termination and ends 63 days after the date the applicable coverage is terminated. For an individual who disenrolls voluntarily, the guaranteed issue time period begins 60 days before the effective date of the disenrollment and ends 63 days after the effective date. If the individual's enrollment is involuntarily terminated within the first 12 months of enrollment, and he or she, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment is considered an initial enrollment.

Another type of eligible person is an individual who, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, or with a PACE provider, and disenrolls within 12 months after the effective date of enrollment. The policy to which the person is entitled must include any Medicare supplement policy offered by any insurer. For an individual whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that he or she receives a notice of termination and ends 63 days after the date the applicable coverage is terminated. For an individual who disenrolls voluntarily, the guaranteed issue time period begins 60 days before the effective date of the disenrollment and ends 63 days after the effective date. If the individual's enrollment is involuntarily terminated within the first 12 months of enrollment, and he or she, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is considered an initial enrollment.

For the last two categories of eligible individuals, enrollment of an individual with an organization, provider, or plan described in these provisions may not be considered an initial enrollment after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, or plan.

For an eligible person whose guaranteed issue time period is not described above, the guaranteed issue time period begins on the

effective date of disenrollment and ends 63 days after the effective date.

Under the bills, "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in Federal regulations, and includes coordinated care plans that provide health care services, including HMO plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans; medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and Medicare+Choice private fee-for-service plans. A PACE program is a program of all-inclusive care for the elderly as described in the Social Security Act.

Notification Requirements

Under the bills, at the time of an event (described above) that causes an individual to lose coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the insurer terminating the policy, or the administrator of the plan being terminated, respectively, must notify the individual of his or her rights under the bills and of the obligations of insurers of Medicare supplement policies. The notice must be communicated at the same time as the notification of termination.

At the time of an event that causes an individual to cease enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, or the administrator of the plan, respectively, must notify the individual of his or her rights under the bills and of the obligations of insurers. The notice must be communicated within 10 working days of the insurer's receiving notification of disenrollment.

Core Benefits

Under the Code and the Act, every insurer issuing a Medicare supplement insurance policy in Michigan and BCBSM must make available such a policy that includes a basic core package of benefits to each prospective insured. Chapter 38 and Part 4A list the core benefits that must be included. Previously, one of the benefits was coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare deductible. Under the bills, this benefit is coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of Medicare eligible expenses, regardless of hospital confinement, subject to the Medicare deductible.

Outline of Coverage

Chapter 38 and Part 4A require an insurer that offers a Medicare supplement policy or certificate to provide an applicant with an outline of coverage, upon application. Under Part 4A, if an outline of coverage is provided at the time of application and the policy or certificate is issued on a basis that requires revision of the outline, a substitute outline of coverage properly describing the certificate must accompany the certificate when it is delivered, and must contain the following statement:

> Notice: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

Senate Bill 748 added the same provisions to Chapter 38 (referring to a policy or certificate).

Quality Assurance Fee

Senate Bill 748 added Section 224b to the Code to require the DCH to assess a quality assurance fee on each HMO that has in effect a Medicaid managed care contract awarded by the State and administered by the Department at the time of assessment. The fee must equal a percentage established by the DCH that, when applied to each HMO's non-Medicare premiums paid to the HMO, totals an amount that would equal a 5% increase for the Medicaid managed care program net of the value of the fee. The DCH was required to implement the fee on the bill's effective date, and may not the assess or collect it after September 30, 2003.

The quality assurance fee and all Federal matching funds attributed to it must be used to maintain the Medicaid reimbursement rate increase in each fiscal year in which the fee is

first assessed. Only an HMO that is assessed the fee is eligible for the increased Medicaid reimbursement rates under Section 224b.

The fee must be assessed on the non-Medicare premiums collected by an HMO in calendar year 2001. If the HMO did not have non-Medicare premium revenue in 2001, the assessment must be based on the HMO's non-Medicare premiums collected in the immediately preceding quarter.

The DCH must implement Section 224b in a manner that complies with Federal requirements necessary to assure that the fee qualifies for Federal matching funds. If the Department cannot comply with these requirements or cannot use the FY 2001-02 level of support for Federal matching dollars other than for a change in covered benefits or covered population required under the State's Medicaid contract with HMOs, the fee may no longer be assessed or collected.

If an HMO fails to pay the fee, the DCH may assess a penalty of 5% for each month that the fee and penalty are not paid, up to a maximum of 50% of the assessment. The DCH also may refer past due amounts for collection to the Department of Treasury.

The bill established the Medicaid HMO Quality Assurance Assessment Fund in the State Treasury. The DCH must deposit the fee revenue with the State Treasurer for deposit in the Fund, to be used for the purpose described above.

The bill states that in all fiscal years governed by Section 224b, Medicaid reimbursement rates may not be reduced below the Medicaid payment rates in effect on April 1, 2002, as a direct result of the fee. This provision does not apply to a change in reimbursement rates caused by a change in covered benefits or a change in covered populations required under the State's Medicaid contract with HMOs.

The bill appropriated the following amounts to the DCH for FY 2002-03:

Federal revenues	$817,495,900
Medicaid quality assurance assessment	55,747,000
State General Fund/General Purpose	603,538,200
Health plan services	$1,476,781,100

HMO Deductibles

The Insurance Code allows HMOs to have health maintenance contracts with nominal copayments that are required for specific services. Senate Bill 748 also allows HMOs to have health maintenance contracts with deductibles. The bill prohibits an HMO from requiring that contributions be made to a deductible for "preventative health care services" (services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability). The Code had provided that copayments could not exceed 50% of an HMO's reimbursement to an affiliated provider for providing a service to an enrollee. The bill provides that copayments, excluding deductibles, may not exceed that limit.

The bill refers to deductibles, in addition to payments, in provisions that require an HMO's contract and the contract's rates, including nominal copayments, between the HMO and its subscribers to be fair, sound, and reasonable in relation to the services provided; require an HMO contract to include a description of specific benefits and services available within a service area, with respective copayments; and allow an affiliated provider contract to permit affiliated providers to collect copayments directly from enrollees.

MCL 500.3801 et al. (S.B. 748)
550.1216 et al. (S.B. 749)

Legislative Analyst: Claire Layman

FISCAL IMPACT

Senate Bill 748 will have no fiscal impact on State or local government.

Senate Bill 749 has no direct impact on State or local expenditures as the rate increase given Medicaid HMOs is fully funded with a combination of assessment fees and Federal Medicaid dollars.

Fiscal Analyst: John Walker

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