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SFA BILL ANALYSIS

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Senate Bills 748 and 749 (as introduced 10-18-01)
Sponsor: Senator Bev Hammerstrom (S.B. 748)
Senator Bill Bullard, Jr. (S.B. 749)
Committee: Health Policy

Date Completed: 2-26-02

CONTENT

Senate Bill 748 would amend Chapter 38 of the Insurance Code, and Senate Bill 749 would amend Part 4A of the Nonprofit Health Care Corporation Reform Act (which regulates Blue Cross and Blue Shield of Michigan), to revise the provisions in both the Code and the Act that regulate Medicare supplement policies and Medicare supplement certificates, respectively. (A Medicare supplement policy or certificate is insurance that supplements reimbursements under Medicare for hospital, medical, or surgical expenses of individuals eligible for Medicare or Medicare select policies or certificates.) The provisions of Chapter 38 and Part 4A that regulate Medicare supplement policies are nearly identical in content.

The bills would amend Chapter 38 and Part 4A in the same way, to do the following:

-- Provide for the sale of high deductible plans.
-- Add provisions to regulate Medicare+Choice plans (which are now 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 would not be excluded from coverage because of a preexisting condition.
-- Specify individuals who would be eligible for coverage, and prescribe conditions under which people could not be denied coverage.
-- Establish time periods during which eligible individuals would have to be allowed to enroll.
-- Require notification when a plan was terminated.

High Deductible Plans

Chapter 38 and Part 4A allow an insurer 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 would change the amounts in the various plans to reflect changes that have occurred in Federal regulations.

Currently, each plan prescribes the core benefits that must be included, and limits other coverages as specified. The bills would amend Plan F and Plan J to allow for a standardized Medicare supplement high deductible plan, which would include only 100% of covered expenses following payment of the annual high deductible. The annual high deductible would be $1,580 for 2001, adjusted for inflation each year thereafter. The covered expenses would 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 would 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 would consist of out-of-pocket expenses (other than premiums) for services covered by the plans,

and would be in addition to any other specific benefit deductibles.

Suspension of Policy

The bills would require each Medicare supplement policy to provide that benefits and premiums under the policy would have to be suspended at the request of the policyholder if he or she were entitled to benefits under the Social Security Act, and covered under a group health plan. If suspension occurred and if the policyholder lost coverage under the group health plan, the policy would have to be automatically reinstituted effective on the date of loss of coverage, if the policyholder provided notice of the loss within 90 days after the loss and paid the premium attributable to the time period.

The bills would retain current provisions that require a policy to provide that benefits and premiums must be suspended at the request of a policyholder, for a period of up to 24 months in which the policyholder has applied for and is entitled to medical assistance under Medicaid.

Preexisting Condition Exclusion

Under Chapter 38 and Part 4A, an insurer 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 could not exclude benefits based on a preexisting condition if an applicant qualified under the current provisions; submitted an application within the time required under the current provisions; and as of the date of application had had a "continuous period of creditable coverage" of at least six months. If the applicant met these conditions but had had a continuous period of creditable coverage of less than six months, the insurer would have to 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) would have to specify the manner of the reduction.

Except for the preexisting condition restrictions in the bills, and provisions in Section 3833 of Chapter 38 or Section 483 of Part 4A, the bills state that the current provisions would 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, a "continuous period of creditable coverage" would mean 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 greater than 63 days. "Creditable coverage" would mean coverage of an individual provided under a group health plan; health insurance coverage; Part A or Part B of Medicare; 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 would 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 were secondary or incidental to other insurance benefits.

-- The following benefits, if they were provided under a separate policy, certificate, or contract of insurance or were 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 were 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 (which provides for medical and dental care for members, and certain former members, of the armed forces); and similar supplemental coverage provided under a group health plan.

Eligible Persons

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

One type of eligible person would be an individual who was enrolled under an employee welfare benefit plan that provided health benefits supplementing the benefits under Medicare, and that terminated or ceased to provide all those supplemental health benefits to the individual. The individual would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer; and the guaranteed issue time period would begin on the date the individual received a notice of termination or cessation of all supplemental health benefits or, if a notice were not received, notice that a claim had been denied because of a termination or cessation, and would end 63 days after the date of the applicable notice.

An eligible person also would be an individual who was enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances applied; or the individual was 65 years old or older and was enrolled with a PACE provider under the Social Security Act, and there were 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 had been terminated.
-- The organization had terminated or otherwise discontinued providing the plan in the area in which the individual resided.
-- The individual was 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 specific provisions in the Social Security Act; where the individual had not paid premiums on a timely basis or had engaged in disruptive behavior as specified in standards established under that Act; or the plan was terminated for all individuals within a residence area.
-- The individual demonstrated, in accordance with guidelines established by the Secretary, that the organization offering

the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits were available 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 met other exceptional conditions as the Secretary provided.

Under these provisions, the individual would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. Further, for an individual eligible under these provisions whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated.

Further, an eligible person would be an individual who was enrolled with an eligible organization under a contract under provisions 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 a section of the Social Security Act; a health care prepayment plan; or an organization under a Medicare select policy. These provisions would apply to an enrollment that ceased under the same circumstances that would 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 would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. Further, for an individual eligible under these provisions whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin on the date that was 60 days before the effective date of the disenrollment and would end 63 days after the effective date.

In addition, an eligible person would be an individual who was enrolled under a Medicare supplement policy and the enrollment ceased because of the insolvency of the insurer or bankruptcy of the noninsurer organization, or because of 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 would be entitled to a policy that had a benefit package classified as Plan A, B, C, or F, offered by any insurer. If the individual's enrollment ceased because of the insolvency of the insurer, bankruptcy of a noninsurer organization, or other involuntary termination, the guaranteed issue time period would begin on the earlier of the date that the individual received 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 would end 63 days after the date the coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin 60 days before the effective date of the disenrollment and would end 63 days after the effective date. (Under the bills, "bankruptcy" would mean when a Medicare+Choice organization that was not an insurer filed, or had had filed against it, a petition for declaration of bankruptcy and had ceased doing business in the State. "Insolvency" would mean when an insurer licensed to transact the business of insurance in Michigan had had a final order of liquidation entered against it, with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.)

An eligible person also would be an individual who was enrolled under a Medicare supplement policy, terminated enrollment, and subsequently enrolled, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan, any eligible organization under a contract under specified provisions 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 would apply if the enrollee terminated the subsequent enrollment during any period within the first 12 months of the subsequent enrollment during which he or she

was permitted to terminate the subsequent enrollment under a specified provision of the Social Security Act. The Medicare supplement policy to which the person was entitled would be 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 had a benefit package classified as Plan A, B, C, or F, offered by any insurer. For an eligible individual whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin 60 days before the effective date of the disenrollment and would end 63 days after the effective date. If the individual's enrollment were involuntarily terminated within the first 12 months of enrollment, and he or she, without an intervening enrollment, enrolled with another organization or provider, plan, or program, the subsequent enrollment would be considered an initial enrollment.

Another type of eligible person would be an individual who, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolled in a Medicare+Choice plan under Part C of Medicare, or with a PACE provider under a specified provision of the Social Security Act, and disenrolled within 12 months after the effective date of enrollment. The policy to which the person was entitled would have to include any Medicare supplement policy offered by any insurer. For an individual eligible under these provisions whose enrollment was terminated involuntarily, the guaranteed issue time period would begin on the date that he or she received a notice of termination and would end 63 days after the date the applicable coverage was terminated. For an individual who disenrolled voluntarily, the guaranteed issue time period would begin 60 days before the effective date of the disenrollment and would end 63 days after the effective date. If the individual's enrollment were involuntarily terminated within the first 12 months of enrollment, and he or she, without an intervening enrollment, enrolled with another organization or provider, plan, or program, the subsequent enrollment would be considered an initial enrollment.

For the last two categories of eligible individuals, enrollment of an individual with an organization or provider or plan described in the bills could not be considered to be 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 was not described above, the guaranteed issue time period would begin on the effective date of disenrollment and would end 63 days after the effective date.

Under the bills, "Medicare+Choice plan" would mean a plan of coverage for health benefits under Medicare Part C as defined in Federal regulations, and would include coordinated care plans that provide health care services, including, but not limited to, health maintenance organization 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 a Medicare+Choice medical savings account; and Medicare+Choice private fee-for-service plans. A PACE program would be 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 caused an individual to lose coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminated the contract or agreement, the insurer terminating the policy, or the administrator of the plan being terminated, respectively, would have to notify the individual of his or her rights under the bills and of the obligations of insurers of Medicare supplement policies. The notice would have to be communicated at the same time as the notification of termination.

At the time of an event that caused an individual to cease enrollment under a contract or agreement, policy, or plan, the organization that offered 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, would have to notify the individual of his or her rights under the bills and of the obligations of insurers. The notice would have to be communicated within 10 working days of the insurer's receiving notification of disenrollment.

Core Benefits

Currently, every insurer issuing a Medicare supplement insurance policy in Michigan 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. One of the benefits is 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 would be 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 to provide an applicant with an outline of coverage, upon application. Senate Bill 748 provides that if an outline of coverage were provided at the time of application and the policy or certificate were issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate would have to accompany the policy or certificate when it was delivered, and would have to 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.

(This provision is already in Part 4A.)

MCL 500.3801 et al. (S.B. 748)
550.1451 et al. (S.B. 749)

Legislative Analyst: George Towne

FISCAL IMPACT

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

Fiscal Analyst: John Walker

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