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BILL ANALYSIS

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Senate Bill 744 (Substitute S-1 as passed by the Senate) *(as enrolled)*
House Bill 5235 (Substitute S-1 as reported) *(as enrolled)*
Sponsor: Senator Alan Sanborn (S.B. 744)
Representative Barb Byrum (H.B. 5235)
Senate Committee: Economic Development and Regulatory Reform
House Committee: Insurance (H.B. 5235)

Date Completed: 11-16-09

CONTENT

House Bill 5235 (S-1) would amend Chapter 38 (Medicare Supplemental Policies and Certificates) of the Insurance Code to revise requirements pertaining to Medicare supplemental insurance policies (also called Medigap policies). The bill would do all of the following:

-- Establish new Medigap policy standards that would apply to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date on or after June 1, 2010.
-- Specify that current Medigap policy standards would apply only to Medicare supplement policies or certificates delivered or issued for delivery on or after June 2, 1992, with an effective date for coverage before June 1, 2010.
-- Eliminate certain Medicare supplement plans and add others.
-- Eliminate requirements for at-home recovery benefits and include a new hospice-care benefit as a core benefit in every Medigap plan.
-- Establish requirements for a "2010 standardized Medicare supplement benefit plan" and the exchange of a "1990 standardized Medicare supplement benefit plan" for a 2010 standardized plan.
-- Specify that an insurer would not have to justify to the Commissioner of Financial and Insurance Regulation if the insured replaced a 1990 plan with a 2010 plan.

The bill also would prohibit an insurer from applying new preexisting condition limitations or a new incontestability period to a new Medigap policy for benefits contained in an exchanged 1990 standardized policy, but allow preexisting condition limitations of up to six months on any added benefits contained in a new 2010 standardized policy.

Senate Bill 744 (S-1) would amend Chapter 38 to do the following:

-- Prohibit an insurer of a Medicare supplement policy or certificate from denying or conditioning coverage, or discriminating in pricing, on the basis of genetic information.
-- Prohibit a Medicare supplement insurer from requesting or requiring a genetic test.
-- Allow an insurer to obtain and use genetic test results for the purpose of making a payment determination, pursuant to Federal regulations.
-- Allow an insurer to request, but not require, an individual to undergo genetic testing voluntarily under certain circumstances.
-- Prohibit an insurer from requesting, requiring, or purchasing genetic information for underwriting purposes.

Senate Bill 744 (S-1) specifies that it would apply to all Medicare supplement policies or certificates delivered, issued for delivery, or renewed on or after May 21, 2009.

The bills are tie-barred.

House Bill 5235 (S-1)

Medicare Supplement Plans & Policies

The bill proposes reforms required by Federal law, based on model legislation developed by the National Association of Insurance Commissioners (NAIC). It generally specifies that current Medigap policy standards would apply to Medicare supplement policies or certificates delivered or issued for delivery on or after June 2, 1992, with an effective date for coverage before June 1, 2010.

The bill would establish new Medigap policy standards (largely consistent with the current standards) that would apply to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. The proposed standards generally would differ from the current standards in that the proposed standards would not include requirements for prescription drug benefits (which are now available under Medicare Part D). The bill also would eliminate from Medigap requirements Plans H, I, and J (which contain prescription drug benefits) and Plan E (which essentially would be identical to Plan D (after the preventive care and at-home recovery benefits were removed, pursuant to the Federal requirements).

The bill also would create a new Plan M and Plan N for Medigap policies. Plan M would have increased cost-sharing (50% coverage of the Medicare Part A deductible, and no coverage for the Part B deductible) and Plan N would use a new copay structure ($10 copay for physician visits, and $50 copay on emergency room visits) with no coverage for the Medicare Part B deductible.

In addition, the bill would eliminate requirements for at-home recovery benefits, which are offered by some of the Medigap plans, and include a new hospice-care benefit as a core benefit to every Medigap plan. It also would increase from 80% to 100% the Medicare Part B excess benefit required in Medigap Plan G.

Chapter 38 includes forms illustrating the benefits and coverages for each Medigap plan. The bill would revise those forms to reflect the changes discussed above.

Exchange of Medigap Plans

Under the bill, if an insurer made a written offer to Medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 standardized plan to a 2010 standardized plan, the offer and subsequent exchange would have to comply with the requirements described below.

An insurer would not have to provide justification to the Commissioner of Financial and Insurance Regulation if the insured replaced a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced were priced on an issue age rate schedule at the time of that offer, the rate charged to the insured for the new exchanged policy would have to recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer would have to be filed with the Commissioner.

The rating class of the new policy or certificate would have to be the class closest to the insured's class of the replaced coverage.

An insurer could not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but could apply preexisting condition limitations of not more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.

The new policy or certificate would have to be offered to all policyholders or certificate holders within a given plan, unless the offer or issue would violate State or Federal law.

The bill would define "1990 standardized Medicare supplement benefit plan", "1990 standardized benefit plan", or "1990 plan" as a group or individual policy of Medicare

supplement insurance issued on or after June 2, 1992, with an effective date for coverage before June 1, 2010, including Medicare supplement insurance policies and certificates renewed on or after that date that are not replaced by the issuer at the request of the insured.

The bill would define "2010 standardized Medicare supplement benefit plan", "2010 standardized benefit plan", or "2010 plan" as a group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

Senate Bill 744 (S-1)

Prohibited Uses of Genetic Info

Under the bill, an insurer of a Medicare supplement policy or certificate could not do either of the following:

-- Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to that individual.
-- Discriminate in the pricing of an individual's policy or certificate, including the adjustment of premium rates, on the basis of the genetic information with respect to that individual.

To the extent otherwise permitted by law, this prohibition would not limit the ability of an insurer to do either of the following:

-- Deny or condition the issuance or effectiveness of a policy or certificate, or increase the premium for a group, based on the manifestation of a disease or disorder of an insured or applicant.
-- Increase the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who was covered under the policy.

The manifestation of a disease or disorder in one individual, however, could not be used as genetic information about other group members and to increase the group's premium further.

"Insurer of a Medicare supplement policy or certificate" would include a third-party administrator or other person acting for or on behalf of that insurer.

"Genetic information" would mean, with respect to any individual, information about his or her genetic tests, the genetic tests of his or her family members, and the manifestation of a disease or disorder in his or her family members. Genetic information would include any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman would include genetic information of any fetus carried by her or, with respect to an individual or family member using reproductive technology, genetic information of any embryo legally held by an individual or family member. Genetic information would not include information about the gender or age of any individual. "Family member" would mean any other individual who is a first-, second-, third-, or fourth-degree relative of the individual.

"Genetic services" would mean a genetic test; genetic counseling, including obtaining, interpreting, or assessing genetic information; or genetic education.

"Genetic test" would mean an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. Genetic test would not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

Genetic Testing

The bill would prohibit an insurer of a Medicare supplement policy or certificate from requesting or requiring an individual, or a family member of that individual, to undergo a genetic test. This would not preclude an insurer from obtaining and using the results of a genetic test in making a determination regarding payment, as

defined for the purposes of applying Federal regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act (HIPAA). An insurer could request only the minimum amount of information necessary to accomplish this purpose.

(The Federal provisions establish standards for the disclosure of individual health information, and penalties for the wrongful disclosure of that information, but exclude from those standards an entity engaged in activities of a financial institution or engaged in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments for a financial institution with respect to those activities, including the use or disclosure of information for those activities related to health plan premiums or health care.)

An insurer of a Medicare supplement policy or certificate could request, but not require, that an individual or a family member of that individual undergo a genetic test if each of the following conditions were met:

-- The request was made pursuant to research that complied with 45 CFR Part 46 (Federal regulations that deal with the protection of human subjects in research), and any applicable State or local law or regulations for the protection of human subjects in research.
-- The insurer clearly indicated to each individual to whom a request was made, or to the legal guardian of a minor child, that compliance with the request was voluntary and that noncompliance would have no effect on enrollment status or premium or contribution amounts.
-- Collected or acquired genetic information was not used for underwriting; determination of eligibility to enroll or maintain enrollment status; premium rates; or the issuance, renewal, or replacement of a policy or certificate.
-- The insurer gave the Commissioner of Financial and Insurance Regulation written notice that it was conducting activities pursuant to this exception, including a description of the activities conducted.
-- The insurer complied with any other conditions the Commissioner required by regulation for activities conducted under this exception.

Use of Genetic Info for Underwriting

The bill would prohibit an insurer of a Medicare supplement policy or certificate from requesting, requiring, or purchasing genetic information for underwriting purposes. "Underwriting purposes" would mean all of the following:

-- Rules for or determination of eligibility, including enrollment and continued eligibility, for benefits under the policy.
-- The computation of premium or contribution amounts under the policy.
-- The application of any preexisting condition exclusion under the policy.
-- Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

A Medigap insurer also could not request, require, or purchase genetic information with respect to any individual before that individual's enrollment under the policy in connection with that enrollment. If an insurer obtained genetic information incidental to requesting, requiring, or purchasing other information concerning any individual, that request, requirement, or purchase would not violate this prohibition if the information were not requested, required, or purchased for underwriting purposes.

Proposed MCL 500.3829a (S.B. 744)
MCL 500.3801 et al. (H.B. 5235)

BACKGROUND

Medicare

According to the U.S. Department of Health and Human Services (HHS) website, people who are at least 65 years old, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease are eligible for Medicare. There are two tracks within the Medicare system under which most people receive coverage. The Original Medicare plan consists of hospital benefits under Part A, medical benefits under Part B, prescription drug coverage under Part D, and a Medigap policy. Medicare Advantage, called "Part C", combines Part A and B benefits and includes prescription drug coverage under Part D.

Medigap Policies

Medicare supplement insurance policies are sold by private insurance companies to help cover costs not covered by the Original Medicare plan. Federal and state law prescribes standards that Medigap policies must meet, including specific benefits. Currently, there are 12 different standardized Medigap policies (Plans A through L). Enrollees generally must pay a monthly premium for their Medigap policies, in addition to any premiums for coverage under Medicare Parts A and B.

Medicare Modernization & NAIC Medigap Model Regulations

Congress has established minimum Federal standards that the NAIC has incorporated into its Medigap model regulation. As long as a state's Medigap regulations meet or exceed the Federal minimum standards, the state may retain its jurisdiction over Medigap regulation.

Medigap plans were standardized nationwide in 1990 into a uniform set of benefit plan packages. Upon the enactment of the Federal Medicare Modernization Act in 2003, which created a voluntary Medicare out-patient prescription drug benefit (Medicare Part D), Congress encouraged the NAIC to modernize the 1990 Medigap benefit packages. The NAIC subsequently developed new standard plans in a revised Medigap model regulation. In 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which directed the Secretary of the HHS to implement the NAIC Medigap model regulations, as amended by Congress, to meet additional Medigap standards established in MIPPA and in the Federal Genetic Information Nondiscrimination Act, which also was enacted in 2008.

In September 2008, the NAIC approved amendments to its Medigap model regulations, to reflect the Federal requirements, and states must incorporate these new Federal standards into their laws and regulations. The earliest effective date for coverage under a 2010 standardized plan policy meeting the new Federal requirements is June 1, 2010. The date also is the cut-off date for carriers issuing policies with the 1990 standardized benefit packages.

FISCAL IMPACT

House Bill 5235 (S-1)

The bill would have no fiscal impact on State or local government. It would bring the State into compliance with current Federal regulations regarding Medicare supplement insurance policies. Staff from the Office of Financial and Insurance Regulation have indicated that states that fail to come into compliance with revised Federal law on these policies will be subject to Federal regulation of these types of policies.

Senate Bill 744 (S-1)

Because Medicare is a federally funded program, the bill would have no fiscal impact on State or local government.

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