THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3811a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; basic core benefits; availability; sale of certain benefits prohibited; structure, language, designation, and format; other designations; requirements.

Sec. 3811a. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. A policy or certificate must not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3811.

(2) An insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807a. If an insurer makes available any of the additional benefits described in section 3809a or offers standardized benefit plans K or L, the insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing either standardized benefit plan C or standardized benefit plan F.

(3) Groups, packages, or combinations of Medicare supplement benefits other than those listed in this section must not be offered for sale in this state except as may be permitted in subsection (6)(k).

(4) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans in subsection (6) and must conform to the definitions in this chapter. Each benefit must be structured in accordance with sections 3807a and 3809a and list the benefits in the order shown in subsection (6). As used in this section, "structure, language, designation, and format" means style, arrangement, and overall content of a benefit.

(5) In addition to the benefit plan designations as provided under subsection (6), an insurer may use other designations to the extent permitted by law.

(6) A Medicare supplement insurance benefit plan must conform to 1 of the following:

(a) A standardized Medicare supplement benefit plan A must be limited to the basic core benefits common to all benefit plans as required under section 3807a.

(b) A standardized Medicare supplement benefit plan B must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible as defined in section 3809a(2)(a).

(c) A standardized Medicare supplement benefit plan C must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), and (f).

(d) A standardized Medicare supplement benefit plan D must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f).

(e) A standardized Medicare supplement benefit plan F must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). A standardized Medicare supplement plan F high deductible must include only the following: 100% of covered expenses following the payment of the annual high-deductible plan F deductible. The covered expenses include the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). The annual high-deductible plan F deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and must be in addition to any other specific benefit deductibles. The annual high-deductible plan F deductible is $1,500.00 for calendar year 1999, and the secretary shall adjust it annually thereafter to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(f) A standardized Medicare supplement benefit plan G must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as

defined in section 3809a(2)(a), (c), (e), and (f). Effective January 1, 2020, the standardized plan F high deductible benefit plan, redesignated in section 3811b(2)(d) as plan G high deductible, may be offered to an individual who was eligible for Medicare before January 1, 2020.

(g) Standardized Medicare supplement benefit plan K must consist of the following:

(*i*) Coverage of 100% of the part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period.

(*iii*) On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(*iv*) Medicare part A deductible: coverage for 50% of the Medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*v*) Skilled nursing facility care: coverage for 50% of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare part A until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vi*) Hospice care: coverage for 50% of cost sharing for all part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vii*) Coverage for 50%, under Medicare part A or B, of the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*viii*) Except for coverage provided in subparagraph (*ix*), coverage for 50% of the cost sharing otherwise applicable under Medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*ix*) Coverage of 100% of the cost sharing for Medicare part B preventive services after the policyholder pays the part B deductible.

(*x*) Coverage of 100% of all cost sharing under Medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare parts A and B of $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States Department of Health and Human Services.

(h) Standardized Medicare supplement benefit plan L must consist of the following:

(*i*) The benefits described in subdivision (g)(*i*), (*ii*), (*iii*), and (*ix*).

(*ii*) The benefits described in subdivision (g)(*iv*), (*v*), (*vi*), (*vii*), and (*viii*), but substituting 75% for 50%.

(*iii*) The benefit described in subdivision (g)(*x*), but substituting $2,000.00 for $4,000.00.

(i) A standardized Medicare supplement benefit plan M must include only the following: the core benefits as required under section 3807a and 50% of the Medicare part A deductible, skilled nursing care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(b), (c), and (f).

(j) A standardized Medicare supplement benefit plan N must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f) with copayments in the following amounts:

(*i*) The lesser of $20.00 or the Medicare part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(*ii*) The lesser of $50.00 or the Medicare part B coinsurance or copayment for each covered emergency room visit. The copayment must be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare part A expense.

(k) New or innovative benefits: an insurer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. The innovative benefit must not include an outpatient prescription drug benefit. New or innovative benefits must not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218