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BILL ANALYSIS

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House Bill 6359 (Substitute H-2 as passed by the House)
Sponsor: Representative Richard Ball
House Committee: Health Policy
Senate Committee: Health Policy

Date Completed: 11-27-06

CONTENT

The bill would amend Chapter 38 (Medicare Supplement Policies and Certificates) of the Insurance Code to do the following:

-- Refer to "Medicare Advantage" rather than "Medicare + Choice".
-- Repeal regulations of the Nonprofit Health Care Corporation Reform Act (which regulates Blue Cross and Blue Shield of Michigan, or BCBSM) pertaining to Medicare supplement certificates, and provide that Chapter 38 would apply to those certificates offered by BCBSM.
-- Prescribe standards for Medicare supplement benefit Plans K and L.
-- Provide that a Medicare supplement policy could include outpatient prescription drug coverage until January 1, 2006.
-- Prohibit a Medical supplement benefit Plan H, I, or J from including an outpatient prescription drug benefit after December 31, 2005.
-- Require an insurer offering a Medicare supplement policy to comply with notice requirements of the Federal Medicare Prescription Drug, Improvement, and Modernization Act.
-- Revise information required to be on applications for and outlines of Medicare supplement policies to reflect changes proposed by the bill.
-- Require the renewal of supplement policies in existence before January 1, 2006, that include a prescription drug benefit for policyholders who opted not to enroll in Medicare Part D; and prohibit such a policy from being renewed after the policyholder enrolled in Part D, unless that benefit were eliminated and premiums adjusted to reflect the reduced coverage.
-- Prohibit an insurer from issuing a Medicare supplement policy or certificate to an individual enrolled in Medicare Advantage unless the effective date of the coverage was after the termination date of the individual's Medicare Advantage coverage.

The bill is described below in further detail. (The Medicare program and supplement policies (also called Medigap policies) are described under **BACKGROUND**.)

Scope of Chapter 38

Part 4A of the Nonprofit Health Care Corporation Reform Act regulates Medicare supplement certificates offered by BCBSM. The bill would repeal Part 4A and include BCBSM in the definition of "insurer" under Chapter 38.

The bill also specifies that Chapter 38 would apply to a Medicare supplement policy delivered, issued for delivery, or renewed by BCBSM on or after the bill's effective date.

Under the Code, "Medicare supplement policy" means an individual or group policy or certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of people eligible for Medicare and Medicare select policies and certificates. The bill would exclude from the definition "Medicare Advantage" plans established under

Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan providing benefits under an agreement under Section 1833(a)(1)(A) of the Social Security Act.

(That section pertains to an organization that provides medical and other health services under Part B, or arranges for their availability, on a prepayment basis, and either is sponsored by a union or employer, or does not provide or arrange for the provision of any inpatient hospital services.)

Currently, as used in a Medicare supplement policy, "Medicare eligible expenses" means health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. The bill would refer to health care expenses of the kinds covered by Parts A and B of Medicare.

Supplement Plans K & L

The bill would prescribe standards for Plans K and L. Standardized Medicare supplement benefit Plan K would have to consist of the following:

-- Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st day through the 90th day in any Medicare benefit period.
-- Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st day through the 150th day in any Medicare benefit period.
-- Upon 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.
-- Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation was met as described below.
-- Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation was met.
-- Coverage for 50% of cost sharing for all Part A Medicare-eligible expenses and respite care until the out-of-pocket limitation was met.
-- Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three 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 was met.
-- Coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder paid the Part B deductible until the out-of-pocket limitation was met, except as otherwise provided.
-- Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder paid the Part B deductible.
-- Coverage of 100% of all cost sharing under Parts A and B for the balance of the calendar year after the individual had reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services (HHS).

With regard to the coverage upon exhaustion of the hospital inpatient coverage, the provider would have to accept the insurer's payment as payment in full and could not bill the insured for any balance.

Standardized Medicare supplement Plan L would have to consist of the following:

-- The same benefits as Plan K regarding hospital coinsurance, hospitalization upon exhaustion of the Medicare hospital inpatient coverage, and cost sharing for Part B preventive services.
-- The same benefits as Plan K regarding Part A inpatient hospital care, skilled nursing facility care, hospice care, blood or packed red blood cells, and Part B cost sharing (excluding cost sharing for preventive services), but substituting 75% for 50%.
-- The benefit regarding all cost sharing under Parts A and B after the out-of-pocket limitation had been reached, but substituting $2,000 for $4,000.

A Plan K or L could consist only of the specified benefits.

Additional Benefits

In addition to the required basic core benefits, a Medicare supplement policy may include other specified benefits, including basic and extended outpatient prescription drug coverage. The bill specifies that prescription drug coverage could be included for sale or issuance in a supplement policy until January 1, 2006.

Additional benefits also may include coverage for specified preventive health services, including any of the following screening tests and services, whose frequency is determined to be medically appropriate:

-- Digital rectal examination.
-- Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.
-- Pure tone, air only, hearing screening test, administered or ordered by a physician.
-- Serum cholesterol screening every five years.
-- Thyroid function test.
-- Diabetes screening.
-- Tetanus and diphtheria booster every 10 years.
-- Any other tests or preventive measures determined appropriate by the attending physician.

Under the bill, the coverage would apply to preventive health services not covered by Medicare. The bill would eliminate references to specific tests and services.

New or innovative benefits also may be included in a Medicare supplement policy. The bill specifies that the innovative benefit could not include an outpatient prescription drug benefit after December 31, 2005.

The Code prescribes an annual deductible for high-deductible Plans F and J of $1,580, starting in 2001, and requires the HHS Secretary to adjust it annually to account for inflation. The bill would increase the deductible to $1,790, starting in 2006.

The bill would prohibit a standardized Medicare supplement benefit Plan H, I, or J from including an outpatient prescription drug benefit after December 31, 2005.

Outline of Coverage & Notice Requirements

The Code requires an insurer that offers a Medicare supplement policy to give an applicant an outline of coverage and, except for direct response solicitation policies, to obtain an acknowledgment of receipt. The bill also would require insurers to comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108-173).

The Code prescribes the format and content of the outline of coverage, including notices to applicants regarding cost-sharing and out-of-pocket limits. The bill would revise the content to reflect the proposed changes in coverage, elimination of outpatient prescription drug coverage, and increases in deductibles.

Medicare Select Insurer

The Code requires a Medicare select insurer (an insurer offering or seeking to offer a Medicare supplement policy or certificate that contains restricted network provisions) to make to each applicant full and fair disclosure in writing of the provisions, restrictions, and limitations of the policy or certificate, including a description of the restricted network provisions, including payments of coinsurance and deductibles if out-of-network providers are used. The bill specifies that, except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers would not count toward the out-of-pocket annual limit contained in Plans K and L.

Guaranteed Renewal

Under the Code, a Medicare supplement policy is guaranteed renewable, and may be terminated only for nonpayment of premium or material misrepresentation. The bill specifies that, if a Medicare policy eliminated an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act, the modified policy would be considered to satisfy the guaranteed renewal requirement.

Continuous Loss

Under the Code, the termination of a supplement policy may not reduce or limit the payment of benefits for any continuous

loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. The bill specifies that receipt of Medicare Part D benefits would not be considered in determining a continuous loss.

Suspended Coverage

The Code requires a Medicare supplement policy to provide that benefits and premiums must be suspended at the policyholder's or certificate holder's request for up to 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Medicaid; or if the person is entitled to Medicare Part A benefits and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. (Under that section, "group health plan" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.)

If a suspension occurs and the policyholder or certificate holder loses entitlement to Medicaid benefits or coverage under the group health plan, the supplement policy automatically must be reinstituted. Reinstituted coverage must be substantially equivalent to coverage in effect before the date of the suspension.

The bill specifies that if the suspended supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees would have to exclude outpatient prescription drug coverage. The policy otherwise would have to provide coverage substantially equivalent to the coverage in effect before the date of the suspension.

Policy Renewal

Under the bill, a Medicare supplement policy with benefits for outpatient prescription drugs in existence before January 1, 2006, would have to be renewed for current policyholders who opted not to enroll in Part D.

The bill would prohibit a Medicare supplement policy with benefits for outpatient prescription drugs from being issued after December 31, 2005. After that date, a supplement policy with outpatient prescription drugs benefits could not be renewed after the policyholder enrolled in Medicare Part D unless the policy was modified to eliminate outpatient prescription coverage for expenses of those drugs incurred after the effective date of the individual's coverage under a Part D plan; and premiums were adjusted to reflect the elimination of prescription drug coverage at the time of Part D enrollment, accounting for any claims paid, if applicable.

Eligible Person

Under Chapter 38, an eligible person is an individual who meets one of several specified criteria. The bill would add a person who enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment, was enrolled under a Medicare supplement policy that covered outpatient prescription drugs, and terminated enrollment in the supplement policy and submitted evidence of enrollment in Part D along with the application for a supplement policy with a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any insurer.

Guaranteed Issue Times

Chapter 38 prescribes guaranteed issue times for Medicare supplement policies. For an individual enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and that terminates or ceases to provide all those supplemental health benefits, 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 applicable notice. Under the bill, for such an individual the guaranteed issue time period would begin on the date he or she received the notice of termination or cessation of supplemental benefits or that a claim had been denied, or the date the applicable

coverage terminated or ceased, whichever occurred later. The issue time would end 63 days after the applicable date.

For a person who enrolled in a Part D plan during the initial enrollment period who, at the time of enrollment, was enrolled in a supplement policy with outpatient prescription drug coverage and the person terminated enrollment in the supplement policy, the guaranteed issue period would begin on the date the person received notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and would end 63 days after the effective date of the individual's Part D coverage.

(Under Section 1882(v)(2)(B) of the Social Security Act, an issuer of a Medicare supplement policy had to give written notice during the 60-day period immediately preceding the initial Part D enrollment period (November 15, 2005, through May 15, 2006) to each holder of a Medigap policy or certificate that included prescription drug coverage of his or her options regarding continued enrollment and prescription drug coverage.)

Requirement to Provide Supplemental Coverage

Under the bill, an insurer offering or renewing individual or group expense-incurred hospital, medical, or surgical policies or certificates after June 27, 2005, could comply with the Code's requirement to provide Medicare supplemental coverage to eligible policyholders by using another insurer to write the coverage, provided the insurer met all of the following requirements:

-- The insurer gave its policyholders the name of the insurer that would provide the supplemental coverage.
-- The insurer gave its policyholders the telephone numbers at which the supplemental insurer could be reached.
-- The insurer remained responsible for providing supplemental coverage to its policyholders in the event that the other insurer no longer provided coverage and another insurer was not found to take its place.
-- The insurer certified to the Commissioner of the Office of Financial and Insurance Services (OFIS) that it was in the process of discontinuing in Michigan its offerings of individual or group policies or certificates.
-- The insurer provided certification from an executive officer for the specific insurer or affiliate wishing to use this option.

The certification from an executive officer would have to identify the process provided to give policyholders the name and telephone numbers of the supplemental insurer, and the insurer to remain responsible for providing coverage if the supplemental insurer no longer provided coverage and no replacement insurer were found. The certification also would have to state clearly that the insurer understood that the OFIS Commissioner could void the arrangement if the affiliate failed to ensure that eligible policyholders immediately were offered Medicare supplemental policies.

Group Policy Termination

The Code requires each Medicare supplement policy to include a renewal or continuation provision. If a group supplement policy is terminated by the group policyholder and is not replaced, the issuer must offer certificate holders an individual supplement policy that, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy or provides for benefits that otherwise meet the requirements of Chapter 38. The bill specifies that, if a Medicare supplement policy eliminated an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act, the modified policy would be considered to satisfy the Code's guaranteed renewal requirements.

Compliance with Federal Law

The bill would require insurers to comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act. An insurer also would have to file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by that Act only with the insurance commissioner in the state in which the policy or certificate was issued.

MCL 500.3801 et al.

BACKGROUND

Medicare

According to the 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.

Part A: Hospital Insurance. Part A benefits are provided by Medicare and help cover inpatient hospital care, including critical access hospitals and skilled nursing facilities, hospice care, and some other health care services. Beneficiaries must meet certain criteria to be eligible for coverage under Part A. Most people do not have to pay a monthly premium for Part A benefits because they paid Medicare taxes while working.

Part B: Medical Insurance. Part B benefits also are provided by Medicare and help cover physician services and outpatient care, as well as some other medical services that Part A does not cover, such as physical and occupational therapists and some home health care. Part B benefits apply to services and supplies that are considered medically necessary. Beneficiaries must pay a monthly premium for Part B coverage (which was $78.20 in 2005), as well as an annual deductible (which was $110 in 2005). Premium and deductible rates may be adjusted annually.

Part C: Medicare Advantage. Part C combines hospital and medical services under plans approved by Medicare and provided by private insurance companies, such as health maintenance organizations and preferred provider organizations. (Part C plans previously were called Medicare + Choice plans.) For some people, premiums and copays are lower in a Medicare Advantage Plan than they would be in the Original Medicare plan. Part C plans must cover medically necessary services, and often include extra benefits. Additionally, most Part C plans cover prescription drugs. Those enrolled in Part C plans without prescription drug coverage may choose that coverage under Part D.

Part D: Prescription Drug Coverage. Enrollment under Part D is optional, and enrollees usually pay a monthly premium. Part D plans are approved by Medicare but offered by private insurers, and must cover medically necessary drugs. An enrollee uses a plan member card to fill prescriptions and is responsible for any copayment and/or deductible. Part D was added to the Medicare Program in 2003 under the Medicare Prescription Drug, Improvement, and Modernization Act.

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.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The bill would affect Medicare supplement policies, commonly known as "Medigap" policies. These Medigap policies provide expanded coverage to Medicare recipients, particularly for pharmaceutical products in concert with the new Medicare Part D program. They have no impact on Medicaid recipients or State and local government employees. Those dually eligible for Medicaid and Medicare have full pharmaceutical coverage through the Medicare Part D program. Therefore, the bill would have no fiscal impact on State or local government.

Fiscal Analyst: Steve Angelotti

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