Act No. 89
Public Acts of 1990
Approved by the Governor
May 31, 1990
Filed with the Secretary of State
June 1, 1990

STATE OF MICHIGAN
85TH LEGISLATURE
REGULAR SESSION OF 1990

Introduced by Reps. Weeks, Dutko, Bartnik, Rocca, Webb, Gire, Clack, Stupak, Porreca, DeMars, Barns, Griffin, Scott, Jaye and Alley

ENROLLED HOUSE BILL No. 4185

AN ACT to amend Act No. 368 of the Public Acts of 1978, entitled as amended "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for penalties and remedies; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding sections 21054c, 21054d, 21054e, 21054f, 21054g, 21054h, 21054i, 21054j, 21054k, 21054*l*, 21054m, 21054n, 21054o, 21054p, 21054q, 21054r, 21054s, and 21054t.

The People of the State of Michigan enact:

Section 1. Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding sections 21054c, 21054d, 21054e, 21054f, 21054g, 21054h, 21054i, 21054j, 21054k, 21054*l*, 21054m, 21054n, 21054o, 21054p, 21054q, 21054r, 21054s, and 21054t to read as follows:

Sec. 21054c. (1) As used in this section and sections 21054d to 21054t:

(a) "Medicare supplemental contract" means a group or individual contract that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. Medicare supplemental contract does not include a medicare supplemental contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations.

(b) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-1a, 1395i-2 to 1395i-3, 1395j to 1395dd, 1395ff to 1395mm, 1395oo to 1395yy, and 1395bbb to 1395ccc.

(2) Each health maintenance organization that offers a medicare supplemental contract in this state shall do so in accordance with this act and the provisions of this section and sections 21054d to 21054t.

(3) The term "medicare supplemental" or words of similar import shall not be used unless the contract is issued in compliance with this section and sections 21054d to 21054t.

Sec. 21054d. (1) A health maintenance organization that offers medicare supplemental coverage shall provide without restriction to a person who permanently resides within the organization's service area, who requests coverage from the organization, and who is enrolled under a health maintenance contract issued by the organization, a right of conversion to a guaranteed renewable or noncancelable medicare supplemental contract that, at a minimum, meets the requirements of section 21054e, if that person would no longer be covered because he or she has become eligible for medicare or if that person loses coverage under a group contract after becoming eligible for medicare. A health maintenance organization that does not offer a medicare supplemental contract or alternative medicare coverage under contract with the federal government shall include a notice of that fact on its enrollment forms.

(2) A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application shall not be entitled to coverage under the medicare supplemental contract until the day following the date of discharge. However, if the hospitalized person was covered by an organization immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group contract after becoming eligible for medicare, the person shall be eligible for immediate coverage from that organization under this section.

(3) A person who wishes coverage under this section shall either request such coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or request such coverage within 180 days after losing coverage under a group health maintenance contract. A person 60 years of age or older who loses coverage under a group health maintenance contract shall be entitled to coverage under a medicare supplemental contract without restriction, other than residency, from the organization subject to this section which provided the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare.

(4) Except as provided in section 21054*l*, a person who was not covered under an individual or group health maintenance contract prior to applying for a medicare supplemental contract as specified in subsection (3) may be offered a medicare supplemental contract that includes a provision for exclusion of preexisting conditions for 6 months after the effective date of coverage.

(5) Each health maintenance organization offering individual health maintenance contracts in this state shall give to each person who is covered by an individual contract with the health maintenance organization at the time he or she becomes eligible for medicare, and to each applicant for individual coverage who is eligible for medicare, written notice of the availability of medicare supplemental coverage under this section. Each group health maintenance contract holder providing health maintenance organization coverage in this state shall give to each subscriber who is covered at the time he or she becomes eligible for medicare written notice of the availability of medicare supplemental coverage under this section.

Sec. 21054e. A health maintenance contract shall not be titled, advertised, solicited, or issued by a health maintenance organization for delivery in this state as a medicare supplemental contract if it does not meet, at a minimum, the requirements of 1 of the following 2 types of medicare supplemental coverage packages, which requirements do not preclude the inclusion of other provisions or benefits if not inconsistent with these standards:

(a) A type 1 medicare supplemental package. A type 1 medicare supplemental package shall cover, at a minimum, the deductible and copayment requirements of part A and part B of the federal medicare program and coverage of 90% of medicare part A eligible expenses for hospitalization not covered by medicare, subject to a lifetime maximum benefit of an additional 365 days.

(b) A type 2 medicare supplemental package. A type 2 medicare supplemental package shall provide the same coverage as a type 1 medicare supplemental package but shall exclude coverage of the part A and part B dollar deductibles, other than deductibles for blood, with an appropriate reduction in rate.

Sec. 21054f. A health maintenance contract shall not be titled, advertised, solicited, or issued by a health maintenance organization for delivery in this state as a medicare supplemental contract if the contract does not meet, at a minimum, the following standards, which do not preclude the inclusion of other provisions or benefits if not inconsistent with these standards:

(a) A medicare supplemental contract shall not exclude coverage for more than 6 months from the effective date of coverage for a preexisting condition. The contract shall not define a preexisting condition more

restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(b) A medicare supplemental contract shall not provide benefits for services needed due to sickness on a different basis than services needed due to accidents.

(c) A medicare supplemental contract shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Rates may be modified to correspond with the changes with the commissioner's approval.

(d) A medicare supplemental contract shall be guaranteed renewable. Termination shall be only as permitted in the contract and approved by the commissioner or as permitted by law.

(e) Termination of a medicare supplemental contract shall not reduce or limit the payment of benefits for any continuous services which commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be predicated upon the continuous total disability of the enrollee, limited to the duration of the contract benefit period, if any, or payment of the maximum benefits.

Sec. 21054g. (1) A health maintenance organization's rate for an individual health maintenance organization medicare supplemental contract shall be determined using the aggregate experience of actual and expected losses for all such contracts issued in each service area or in aggregate service areas by the health maintenance organization.

(2) Each health maintenance organization that issues medicare supplemental contracts for delivery in this state shall comply with sections 1842 and 1882 of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395u and 1395ss, and shall certify that compliance on the medicare supplement insurance experience reporting form.

Sec. 21054h. A medicare supplemental contract shall require that, except for emergency care and specified benefits for services provided outside of the organization's service area, benefits are available only if services are provided or authorized by the organization's employed or affiliated providers in accordance with the organization's procedures.

Sec. 21054i. A medicare supplemental contract shall not be delivered or issued for delivery in this state if the contract provides benefits that duplicate benefits provided by medicare.

Sec. 21054j. (1) Each health maintenance organization marketing medicare supplemental contracts in this state directly or through its agents shall do all of the following:

(a) Establish marketing procedures to ensure that any comparison of contracts by its health benefit agents or enrollment representatives will be fair and accurate.

(b) Establish marketing procedures to ensure excessive coverage is not sold or issued.

(c) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for medicare supplemental coverage already has disability or other health coverage and the types and amounts of any such coverage.

(d) Establish auditable procedures for verifying compliance with this subsection.

(2) In recommending the purchase or replacement of any medicare supplemental coverage, a health benefit agent or enrollment representative shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(3) Any sale of medicare supplemental coverage that will provide an individual with more than 1 medicare supplemental policy, certificate, or contract is prohibited.

(4) A health maintenance organization shall not provide a commission or other compensation to the health maintenance organization's agent or employee for the sale or service of a health maintenance organization contract issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the contract is not more than the amount of the commission or compensation that the health maintenance organization's agent or employee receives for the contract in each of the 2 subsequent, consecutive annual renewal periods.

Sec. 21054k. (1) On or before March 1 of each year, every health maintenance organization providing medicare supplemental coverage in this state shall report to the commissioner the following information for every individual resident of this state for which the health maintenance organization has in force more than 1 medicare supplemental contract:

(a) Contract number.

(b) Date of issuance.

(2) The items in subsection (1) shall be grouped by individual contract holder.

Sec. 21054*l*. If a medicare supplemental contract replaces another medicare supplemental policy, certificate, or contract, the replacing health maintenance organization shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplemental contract for similar benefits to the extent such time was spent under the original coverage.

Sec. 21054m. A medicare supplemental contract shall not use waivers, riders, or any other contract provisions to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

Sec. 21054n. (1) A health maintenance organization shall not issue a medicare supplemental contract to a person who has not applied for or enrolled in part A and part B of the federal medicare program. If it is later determined that a person has not applied for part A and part B of the federal medicare program, the health maintenance organization shall refund all contract payments received from the person for a medicare supplemental contract issued to the person plus interest less the amount of any benefits received by the person under the contract.

(2) As used in this section, interest shall be calculated at 6-month intervals from the date the first contract payment was received at a rate of interest which is equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months immediately preceding July 1 and January 1, as certified by the state treasurer, and compounded annually.

Sec. 21054o. (1) Medicare supplemental contracts shall include a renewal provision. The provision shall be appropriately captioned and shall clearly state the term of coverage for which the contract is issued and for which it may be renewed.

(2) If a medicare supplemental contract contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the contract and must be labeled as "preexisting condition limitations".

(3) As soon as practicable but no later than 45 days after the effective date of any medicare benefit changes, a health maintenance organization providing medicare supplemental contracts delivered or issued for delivery in this state shall file with the commissioner both of the following:

(a) Any appropriate rate adjustments and any supporting documents necessary to justify the adjustments.

(b) Any appropriate forms needed to modify the medicare supplemental contract to adjust benefits or to eliminate benefits under the contract that duplicate benefits provided by medicare. The forms shall provide a clear description of the medicare supplemental benefits provided by the contract.

(4) Upon satisfying the filing and approval requirements, a health maintenance organization providing medicare supplemental contracts delivered or issued for delivery in this state shall provide to each subscriber any form necessary to eliminate benefits under the contract that duplicate benefits provided by medicare.

(5) As soon as practicable but no later than 30 days before the annual effective date of any medicare benefit changes, a health maintenance organization shall notify each subscriber of modifications made to its medicare supplemental contract in a format acceptable to the commissioner. The notice shall be in outline form, contain clear and simple language, shall not contain or be accompanied by any solicitation, and shall include both of the following:

(a) A description of revisions to the medicare program and of each modification made to the coverage provided under the medicare supplemental contract.

(b) Whether a rate adjustment is due to changes in medicare.

Sec. 21054p. (1) Application forms for individual medicare supplemental contracts shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another medicare supplemental policy, certificate, or contract in force or whether a medicare supplemental contract is intended to replace any disability or other health policy, certificate, or contract presently in force:

(a) Do you have another medicare supplemental insurance policy, certificate, or contract in force (including a health care corporation certificate or another health maintenance organization contract)?

(b) Did you have another medicare supplemental policy, certificate, or contract in force during the last twelve (12) months? If so, with which company? If that policy, certificate, or contract lapsed, when did it lapse?

(c) Are you covered by medicaid?

(d) Do you intend to replace any of your medical or health coverage with this contract?

(2) A supplementary application or other form signed by the agent, unless the coverage is sold without an agent, and by the applicant containing the questions in subsection (1)(a) through (d) may be used.

(3) A health benefit agent or enrollee representative shall list on the application form for a medicare supplemental contract any other health maintenance organization contracts he or she has sold to the applicant, including contracts sold that are still in force and contracts sold in the past 5 years that are no longer in force.

(4) Upon determining that a sale will involve replacement, a health maintenance organization shall furnish the applicant with the following notice regarding replacement of disability or other health coverage:

(a) For direct response solicitation replacement contracts, a health maintenance organization shall deliver to the applicant at the time of issuance of the contract the following notice, in substantially the following form:

"Notice to applicant regarding replacement of medicare supplemental coverage

(Health maintenance organization's name and address)

SAVE THIS NOTICE! It may be important to you in the future.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing medicare supplemental coverage and replace it with a contract to be issued by (health maintenance organization name). Your new contract provides thirty (30) days within which you can return it for a full refund minus the amount of any benefits you received under the contract. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage available to you under the new contract. You should review this new coverage carefully, comparing it with all disability and other health coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this medicare supplemental coverage is a wise decision.

1. State law provides that your replacement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. Your health maintenance organization will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new contract for similar benefits to the extent such time was spent or depleted under the original coverage.

2. If you are replacing existing medicare supplemental coverage, you may want to secure the advice of your present insurer, health care corporation, or health maintenance organization or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, read the copy of the application supplied with your new contract and be sure to completely answer all of the questions on the application. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [health maintenance organization name and address] within thirty (30) days if any information is not correct and complete or if any past medical history has been left out of the application."

(b) For replacement contracts that are not direct solicitation policies, a health maintenance organization shall provide to the applicant prior to issuance or delivery of the medicare supplemental contract 1 copy of the following notice signed by the health benefit agent or enrollee representative, except where the coverage is sold without a health benefit agent or enrollee representative, and by the applicant, shall provide a copy to the insurer, health care corporation, or health maintenance organization whose coverage is being replaced, and shall retain an additional signed and dated copy to acknowledge receipt:

"Notice to applicant regarding replacement of medicare supplemental coverage

(Health maintenance organization's name and address)

SAVE THIS NOTICE! It may be important to you in the future.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing medicare supplemental coverage and replace it with a contract to be issued by (health maintenance organization name). Your new contract provides thirty (30) days within which you can return it for a full refund minus the amount of any benefits you received under the contract. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage available to you under the new contract. You should review this new coverage carefully, comparing it with all disability and other health coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this medicare supplemental coverage is a wise decision.

Statement to applicant by health benefit agent or enrollee representative:

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. I believe the replacement of coverage involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. State law provides that your replacement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. Your health maintenance organization will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new contract for similar benefits to the extent such time was spent or depleted under the original coverage.

2. If you are replacing existing medicare supplemental coverage, you may want to secure the advice of your present insurer, health care corporation, or health maintenance organization or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, read the copy of the application supplied with your new contract and be sure to completely answer all of the questions on the application. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. Failure to include all material medical information on an application may provide a basis for the health maintenance organization to deny any future claims and to refund your contract charge as though your contract had never been in force.

_____

Signature of Health Benefit Agent or Enrollee Representative

_____

Typed Name and Address of Health Benefit Agent or Enrollee Representative

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)

_____

(Policy, Certificate, or Contract Number Being Replaced)"

Sec. 21054q. (1) A health maintenance organization shall provide each applicant for a medicare supplemental contract with a medicare supplemental buyer's guide, which shall be furnished at the time of application, and acknowledgment of receipt of the buyer's guide shall be obtained by the health maintenance organization.

(2) As used in this section, "medicare supplemental buyer's guide" means a document substantially similar to the document entitled "guide to health insurance for people with medicare", that was developed by the national association of insurance commissioners and the United States department of health and human services, as adapted to include information concerning the unique features of medicare supplemental coverage offered by health maintenance organizations, as approved by the department and the commissioner.

Sec. 21054r. A health maintenance organization shall provide to a prospective individual subscriber before application for a medicare supplemental contract an outline of coverage, and shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage shall be in substantially the following form, as approved by the commissioner:

(HEALTH MAINTENANCE ORGANIZATION NAME)

MEDICARE SUPPLEMENTAL COVERAGE

OUTLINE OF COVERAGE

Use this outline to compare benefits and premiums among policies, certificates, and contracts.

1. READ YOUR CONTRACT CAREFULLY. This outline of coverage provides a very brief description of the important features of your contract. This is not the contract, and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your health maintenance organization. It is important that you read your contract carefully!

2. After you receive your contract, you have 30 days within which you can return it for a full refund minus the amount of any benefits you received under the contract.

3. Medicare has 2 parts. Part A covers many hospital costs. Part B covers many medical costs. If you are applying for a medicare supplemental contract, you should be eligible for and should have applied for or be enrolled in medicare parts A and B.

4. Medicare supplemental coverage—contracts of this category are designed to supplement medicare by covering some hospital, medical, and surgical services that are partially covered by medicare. Coverage is provided for hospital inpatient charges and some physician charges, and for the deductibles and copayment provisions required under medicare. The contract does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine (delete if this coverage is provided in the contract).

5. Neither (insert health maintenance organization's name) nor the health maintenance organization's agent is connected with medicare.

6. The following is a brief summary of the major benefit gaps in medicare parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the medicare supplemental coverage:

SERVICE	BENEFIT	MEDICARE PAYS	THIS CONTRACT PAYS	YOU PAY
Hospitalization (Part A): Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies, meals, special care units, drugs, lab tests, diagnostic x rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services	First 60 days per benefit period	All but [$592.00]		
	61st to 90th day per benefit period	All but [$148.00] a day		
	91st to 150th day per benefit period (if individual chooses to use 60 nonrenewable lifetime reserve days)	All but [$296.00] a day		
	Beyond 150 days per benefit period	Nothing		
Blood: Part A	Per calendar year	100% after blood deductible (equal to costs for first 3 pints)		
Part B	Per calendar year	80% after blood deductible (equal to costs for first 3 pints) after [$75.00] deductible		
Posthospital skilled nursing care (Part A): Nursing care in a facility approved by medicare	First 20 days per benefit period	100% (after a 3-day prior hospital confinement)		
	21st through 100th day per benefit period	All but [$74.00] a day		
	Beyond 100 days per benefit period	Nothing		

SERVICE	BENEFIT	MEDICARE PAYS	THIS CONTRACT PAYS	YOU PAY
Medical services approved by medicare (Part B): Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, and ambulance	Per calendar year	80% of allowable charge After [$75.00] deductible		
Prescription drugs: out of hospital		Nothing		
Custodial nursing care		Nothing		
Services outside of U.S. or U.S. territories		Nothing		

Date Applicant's Signature

(The organization issuing the contract shall change the bracketed figures each year to reflect current changes.)

7. The outline of coverage shall state if it does or does not cover the following:

(a) Private duty nursing.

(b) Skilled nursing home care costs beyond what is covered by medicare.

(c) Custodial nursing home care costs.

(d) Intermediate nursing home care costs.

(e) Home health care above number of visits covered by medicare.

(f) Physician charges above medicare's reasonable charge.

(g) Drugs other than prescription drugs furnished during a hospital or a skilled nursing facility stay.

(h) Care received outside of the United States.

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, or examinations for eyeglasses or hearing aids.

8. Any other contract benefits not mentioned in the outline of coverage chart summary shall be added to the chart and, if there are corresponding medicare benefits, they shall be shown.

9. The outline of coverage and the contract shall display prominently by type, stamp, or other appropriate means on the first page of the outline of coverage and contract the following:

"Notice to buyer: The contract may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to review carefully all contract limitations."

10. The outline of coverage shall include a statement that the chart summarizing medicare benefits only briefly describes the benefits, and that your local social security office should be consulted for further details and limitations.

11. The outline of coverage shall include the amount of the charge for this contract.

Sec. 21054s. The following acts and practices are prohibited in the marketing or sale of medicare supplemental contracts:

(a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificates, or contracts or insurers, health care corporations, or health maintenance organizations for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, certificate, or contract or to take out a policy, certificate, or contract with another insurer, health care corporation, or health maintenance organization.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of coverage through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of coverage.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of coverage and that contact will be made by a health benefit agent or enrollee representative or health maintenance organization.

Sec. 21054t. Each health maintenance organization providing medicare supplemental coverage in this state shall file with the commissioner for review a copy of any written, radio, or television advertisement for medicare supplemental coverage intended for use in this state at least 45 days before the date the health maintenance organization desires to use the advertising. The filing shall include a sample or photocopy of all applicable medicare supplemental contracts and related forms and the approval status of the contracts and forms.

This act is ordered to take immediate effect.

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Clerk of the House of Representatives.

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Secretary of the Senate.

Approved.....

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Governor.