Act No. 176
Public Acts of 1989
Approved by the Governor
August 21, 1989
Filed with the Secretary of State
August 22, 1989

STATE OF MICHIGAN
85TH LEGISLATURE
REGULAR SESSION OF 1989

Introduced by Senators Carl, Posthumus and Shinkle

ENROLLED SENATE BILL No. 309

AN ACT to amend sections 2265, 2267, 2273, and 2275 of Act No. 218 of the Public Acts of 1956, entitled as amended "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, and associations engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on the business of surplus line agents; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability, and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state, and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance, and with respect to certain claims against uninsured or self-insured persons; and to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; and to provide penalties for the violation of this act," section 2265 as amended and sections 2273 and 2275 as added by Act No. 195 of the Public Acts of 1982 and section 2267 as amended by Act No. 453 of the Public Acts of 1988, being sections 500.2265, 500.2267, 500.2273, and 500.2275 of the Michigan Compiled Laws; and to add section 2272a.

The People of the State of Michigan enact:

Section 1. Sections 2265, 2267, 2273, and 2275 of Act No. 218 of the Public Acts of 1956, section 2265 as amended and sections 2273 and 2275 as added by Act No. 195 of the Public Acts of 1982 and section 2267 as amended by Act No. 453 of the Public Acts of 1988, being sections 500.2265, 500.2267, 500.2273, and 500.2275 of the Michigan Compiled Laws, are amended and section 2272a is added to read as follows:

Sec. 2265. (1) Each insurer offering individual or group hospital, medical, or surgical expense incurred policies in this state shall provide without restriction, to any person who requests coverage from an insurer and has been insured with an insurer subject to this section, if the person would no longer be insured because he or she has become eligible for medicare or if the person loses coverage under a group policy after becoming eligible for medicare, a right of continuation or conversion to a guaranteed renewable or noncancellable medicare supplemental policy which covers, at a minimum, the requirements of a type 1 medicare supplemental package as described in section 2273(1)(a). 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 this subsection until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group policy after becoming eligible for medicare, the person shall be eligible for immediate coverage from the previous insurer under this subsection. A person shall not be entitled to a medicare supplemental policy under this subsection unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under this subsection shall either request coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy shall be entitled to coverage under a medicare supplemental policy without restriction from the insurer providing 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.

(2) A person not insured under an individual or group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a medicare supplemental policy required to be offered under subsection (1), shall be entitled to coverage under a medicare supplemental policy which may include a provision for exclusion from preexisting conditions for 6 months after the inception of coverage, consistent with the provisions of section 2272(2)(a).

(3) Each insurer offering individual hospital, medical, or surgical expense incurred policies in this state shall give to each person who is insured with the insurer at the time he or she becomes eligible for medicare, and to each applicant of the insurer who is eligible for medicare, written notice of the availability of coverage under this section. Each group policyholder providing hospital, medical, or surgical expense incurred coverage in this state shall give to each certificate holder who is covered at the time he or she becomes eligible for medicare, written notice of the availability of coverage under this section.

Sec. 2267. (1) An insurer who offers a medicare supplemental policy shall provide to the applicant at the time of application an outline of coverage and, except for direct response solicitation policies, 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:

(Company Name)

Medicare Supplemental Coverage

Outline of Coverage

1. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is important that you read your policy carefully!

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

3. Medicare supplemental coverage—policies of this category are designed to supplement medicare by covering some hospital, medical, and surgical services which are partially covered by medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by medicare and subject to other limitations which may be set forth in the policy. The policy 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 policy).

4. Neither (insert company's name) nor its agents are connected with medicare.

5. 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 policy 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	Per calendar year	All but [$560.00]		
Posthospital skilled (part A):	First 8 days Per calendar year	All but [$25.50] per day		
Nursing care in a facility approved by medicare	Days 9 through 150 per calendar year	100% of reasonable cost		
	Beyond 150 days per calendar year	Nothing		
Blood: Part A	Per calendar year Single deductible for parts A & B	100% after blood deductible (equal to costs for first 3 pints)		
Part B	Per calendar year Single deductible for parts A & B	80% after blood deductible (equal to costs for first 3 pints)		
Home health services (parts A and B):	Per calendar year 1989	Intermittent skilled nursing care and other services in the home (daily skilled nursing care for up to 21 days or longer in some cases), 100% of covered services and 80% of durable medical services		
	Per calendar year 1990	Intermittent skilled nursing care for up to 7 days a week for up to 38 days and allows for continuation of services under unusual circumstances. For other services, 100% of covered services and 80% of durable medical equipment		
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 reasonable charge (after $75.00 deductible)		

Service	Benefit	Medicare pays	This policy pays	You* pay
Screening mammography (part B) effective January 1, 1990	Biennial	80% of approved charge		
Respite care (part B) as approved by medicare effective January 1, 1990	First 80 hours per calendar year after out of pocket limit or outpatient drug deductible is met	100% of reasonable charge		
	Beyond 80 hours per calendar year	Nothing		
Out-of-pocket maximum (part B):	Per 1990 calendar year	$1,370 consisting of part B $75 deductible, part B blood deductible, and 20% co-insurance		
	Per calendar years following 1990	[$1,370] amount to be adjusted annually by the secretary of health and human services		
Catastrophic drug insurance (part B): Prescription drugs out of hospital	Limited drug benefits: Drugs administered intravenously at home for calendar year 1990	80% of reasonable charge after $550.00 deductible		
	Limited drug benefits: Immunosuppressive drugs after the first year following a transplant for calendar year 1990	50% of reasonable charge after $550.00 deductible		
	Full drug benefits: All outpatient prescription drugs and insulin for calendar year 1991	50% of reasonable charge after $600.00 deductible		
	Full drug benefits: All outpatient prescription drugs and insulin for calendar year 1992	60% of reasonable charge after $652.00 deductible		
	Full drug benefits: All outpatient prescription drugs and insulin for calendar year 1993 and thereafter	80% of reasonable charge after deductible as determined by medicare		
Custodial nursing care		Nothing		
Services outside of U.S. or U.S. territories		Nothing		

*You may be responsible for charges above the medicare approved rate.

Date _____ Applicant's Signature _____

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

6. The policy 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 hospital or 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, examinations for eyeglasses or hearing aids.

7. A description of any policy provision which excludes, eliminates, resists, reduces, limits, delays, or in any other manner operates to qualify payment of a benefit, including the following statements:

(a) The chart summarizing medicare benefits only briefly describes the benefits.

(b) The health care financing administration or its medicare publications should be consulted for further details and limitations.

8. A description of policy provisions respecting renewability or continuation of coverage including any reservations of a right to change the premium.

9. The amount of the premium for this policy.

(2) If the medicare supplemental policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered. The substitute outline shall contain the following statement, in not less than 12-point type, immediately above the company name: "Notice: Read this outline of coverage carefully. It is not the same as the outline of coverage for the policy you applied for. The policy you applied for has not been issued. This policy is different in the following ways: (Note: Company shall list differences.)"

Sec. 2272a. A medicare supplemental insurance policy or certificate shall not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by medicare.

Sec. 2273. (1) All medicare supplemental policies and certificates delivered or issued for delivery in this state shall meet, at a minimum, the requirements of 1 of the following 2 types of medicare supplemental coverage packages:

(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, excluding outpatient prescription drug deductibles.

(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 premium.

(2) Each insurer which issues medicare supplemental policies for delivery in this state shall file annually with the commissioner, on a form and in the manner prescribed by the commissioner, its rates, rating schedule, and supporting documentation including all claims experience of the insurer for medicare supplemental coverage. The filings and schedules shall demonstrate that the actual and expected losses in relation to premiums are in compliance with the applicable loss ratio standards of this state.

(3) Each insurer that issues medicare supplemental policies for delivery in this state shall comply with sections 1842(h)(3)(A) to (B), 1882(b)(1)(B) to (D), and 1882(c)(1) to (3) 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. 2275. (1) Medicare supplemental policies shall include a renewal provision. The provision shall be appropriately captioned and shall clearly state the term of coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, or except as required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplemental policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing and signed by the insured, unless the benefits are required minimum standards for medicare supplemental policies or if the increase in benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) A medicare supplemental policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import, shall include both a definition and an explanation of those terms in its accompanying coverage outline.

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

(5) The term "medicare supplement or words of similar import" shall not be used unless the policy is issued in compliance with sections 2272 and 2273.

(6) As soon as practicable but no later than 45 days after the effective date of any medicare benefit changes, an insurer providing medicare supplemental policies or certificates delivered or issued for delivery in this state shall file with the commissioner both of the following;

(a) Any appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policy or certificate and any supporting documents necessary to justify the adjustment.

(b) Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefits under the policy or certificate that duplicate benefits provided by medicare. The riders, endorsements, and policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or certificate.

(7) Upon satisfying the filing and approval requirements, an insurer providing medicare supplemental policies or certificates delivered or issued for delivery in this state shall provide to each covered policyholder and certificate holder any rider, endorsement, or policy form necessary to eliminate benefits under the policy or certificate that duplicate benefits provided by medicare.

(8) As soon as practicable but no later than 30 days before the annual effective date of any medicare benefit changes, an insurer providing medicare supplemental policies or certificates delivered or issued for delivery in this state shall notify each covered policyholder and certificate holder of modifications made to its medicare supplemental policies or certificates 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 policy.

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

This act is ordered to take immediate effect.

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Secretary of the Senate.

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Clerk of the House of Representatives.

Approved.....

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Governor.