HOUSE BILL No. 4185

February 15, 1989, Introduced by Reps. Weeks, Dutko, Bartnik, Rocca, Webb, Gire, Clack, Stupak, Porreca, DeMars, Barns, Griffin, Scott, Jaye and Alley and referred to the Committee on Insurance.

A bill to amend Act No. 368 of the Public Acts of 1978, entitled as amended

"Public health code,"

as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding sections 21054a, 21054b, 21054c, 21054d, 21054e, and 21054f.

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 21054a, 21054b, 21054c, 21054d, 21054e, and 21054f to read as follows:

SEC. 21054A. (1) EACH HEALTH MAINTENANCE ORGANIZATION WHICH OFFERS MEDICARE SUPPLEMENTAL COVERAGE IN THIS STATE SHALL DO SO IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION AND SECTIONS 21054B TO 21054F.

(2) A HEALTH MAINTENANCE ORGANIZATION WHICH OFFERS MEDICARE SUPPLEMENTAL COVERAGE SHALL PROVIDE 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 AN ORGANIZATION WHICH IS SUBJECT TO THIS SECTION, A RIGHT OF CONVERT TO A GUARANTEED RENEWABLE OR NONCANCELABLE MEDICARE SUPPLEMENTAL CONTRACT WHICH, AT A MINIMUM, MEETS THE REQUIREMENTS OF SECTION 21054B, 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.

(3) 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 THE 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 THE PREVIOUS ORGANIZATION UNDER THIS SECTION.

(4) A PERSON SHALL NOT BE ENTITLED TO A MEDICARE SUPPLEMENTAL CONTRACT UNDER THIS SECTION UNLESS THE PERSON PRESENTS SATISFACTORY PROOF TO THE HEALTH MAINTENANCE ORGANIZATION THAT HE OR SHE WAS COVERED BY AN ORGANIZATION SUBJECT TO THIS SECTION AND IS ENROLLED IN PART A AND PART B OF MEDICARE. 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.

(5) A PERSON WHO WAS NOT COVERED UNDER A NONGROUP OR GROUP HEALTH MAINTENANCE CONTRACT PRIOR TO APPLYING FOR A MEDICARE SUPPLEMENTAL CONTRACT AS SPECIFIED IN SUBSECTION (4) 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.

SEC. 21054B. (1) A 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 WHICH ARE 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 COINSURANCE 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 PACKAGE BUT SHALL EXCLUDE COVERAGE OF THE PART A AND PART B DOLLAR DEDUCTIBLES, WITH AN APPROPRIATE REDUCTION IN SUBSCRIPTION CHARGE.

(2) 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. PREMIUMS MAY BE MODIFIED TO CORRESPOND WITH THE CHANGES.

(3) 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. 21054C. (1) A HEALTH MAINTENANCE ORGANIZATION WHICH PROVIDES A MEDICARE SUPPLEMENTAL CONTRACT TO A PERSON ENROLLED IN MEDICARE SHALL PROVIDE THE SUBSCRIBER WITH A MEDICARE SUPPLEMENTAL BUYER'S GUIDE.

(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", WHICH WAS DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE

COMMISSIONERS AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, BUT WHICH HAS BEEN 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. 21054D. A HEALTH MAINTENANCE ORGANIZATION WHICH OFFERS A CONTRACT TO SUPPLEMENT THE FEDERAL MEDICARE PROGRAM SHALL PROVIDE TO A PROSPECTIVE NONGROUP SUBSCRIBER BEFORE APPLICATION AND TO A NONGROUP SUBSCRIBER UPON REQUEST BEFORE RENEWAL A COVERAGE OUTLINE, AND SHALL OBTAIN AN ACKNOWLEDGMENT OF RECEIPT OF THE OUTLINE OF COVERAGE FROM THE APPLICANT BY OBTAINING THE SIGNATURES OF THE AGENT OR ENROLLMENT REPRESENTATIVE AND THE APPLICANT ON A COPY OF THE OUTLINE OF COVERAGE. THE OUTLINE OF COVERAGE SHALL BE IN SUBSTANTIALLY THE FOLLOWING FORM, AS APPROVED BY THE COMMISSIONER, UNLESS AN ALTERNATIVE FORM IS APPROVED BY THE COMMISSIONER AND THE DEPARTMENT WHICH PROVIDES SUBSTANTIALLY THE SAME INFORMATION:

(HEALTH MAINTENANCE ORGANIZATION NAME)

MEDICARE SUPPLEMENTAL COVERAGE

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. 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, BUT YOU ARE NOT ENROLLED IN MEDICARE PART B, YOU SHOULD READ THIS NOTICE CAREFULLY. IF YOU ARE NOT ENROLLED IN MEDICARE PART B, IT IS PROBABLY TO YOUR ADVANTAGE TO BUY MEDICARE PART B COVERAGE BEFORE YOU CONSIDER BUYING A MEDICARE SUPPLEMENTAL CONTRACT. ALTHOUGH THE COST CHANGES YEARLY, IN [1988] MEDICARE PART B COVERAGE WAS AVAILABLE AT A COST OF [$27.90] PER MONTH. THIS IS AN EXCELLENT BUY BECAUSE THE FEDERAL GOVERNMENT SUBSIDIZES MORE THAN 2/3 OF THE ACTUAL COST OF THE COVERAGE. (THE HEALTH MAINTENANCE ORGANIZATION ISSUING THE CONTRACT SHALL CHANGE THE BRACKETED FIGURES EACH YEAR TO REFLECT THE PROPER FIGURES.)

3. MEDICARE SUPPLEMENTAL COVERAGE--CONTRACTS 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, AND FOR THE DEDUCTIBLES AND CO-PAYMENT 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).

4. THE (INSERT HEALTH MAINTENANCE ORGANIZATION'S NAME) CONTRACT IS NOT CONNECTED WITH MEDICARE.

5. (INSERT HEALTH MAINTENANCE ORGANIZATION'S NAME) IS NOT 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	PER CALENDAR YEAR	ALL BUT [$560.00]		
POSTHOSPITAL SKILLED (PART A): NURSING CARE IN A FACILITY APPROVED BY MEDICARE	FIRST 8 DAYS PER CALENDAR YEAR	ALL BUT [$25.50] PER DAY		
	DAYS 9 THROUGH 150 PER CALENDAR YEAR	100% OF REASONABLE COST		
	BEYOND 150 DAYS PER CALENDAR YEAR	NOTHING		

MEDICAL SERVICES APPROVED BY MEDICARE (PART B): PHYSICIAN'S SERVICES, IN-PATIENT AND OUT-PATIENT MEDICAL SERVICES AND SUPPLIES AT A HOSPITAL, PHYSICAL AND SPEECH THERAPY, AND AMBULANCE	PER CALENDAR YEAR	80% OF REASONABLE CHARGE (AFTER $75.00 DEDUCTIBLE)
SCREENING MAMMOGRAPHY (PART B) EFFECTIVE JANUARY 1, 1990	BIENNIAL	80% OF REASONABLE 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
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

AGENT OR ENROLLMENT REPRESENTATIVE'S SIGNATURE DATE APPLICANT'S SIGNATURE

(THE ORGANIZATION ISSUING THE CONTRACT SHALL CHANGE THE BRACKETED FIGURES EACH YEAR TO REFLECT CURRENT CHANGES.)

7. THE CONTRACT SHALL STATE IF IT DOES OR DOES NOT COVER THE FOLLOWING:

(A) PRIVATE DUTY NURSING.

(B) HOME HEALTH CARE ABOVE NUMBER OF VISITS COVERED BY MEDICARE.

(C) PHYSICIAN CHARGES ABOVE MEDICARE'S REASONABLE CHARGE.

(D) DRUGS OTHER THAN PRESCRIPTION DRUGS FURNISHED DURING A HOSPITAL OR A SKILLED NURSING FACILITY STAY.

(E) DENTAL CARE OR DENTURES, CHECKUPS, ROUTINE IMMUNIZATIONS, COSMETIC SURGERY, ROUTINE FOOT CARE, OR EXAMINATIONS FOR EYEGLASSES OR HEARING AIDS.

8. A STATEMENT THAT THE CHART SUMMARIZING MEDICARE BENEFITS ONLY BRIEFLY DESCRIBES THE BENEFITS, AND THAT THE HEALTH CARE FINANCING ADMINISTRATION OR ITS MEDICARE PUBLICATIONS SHOULD BE CONSULTED FOR FURTHER DETAILS AND LIMITATIONS.

9. THE AMOUNT OF THE PREMIUM FOR THIS CONTRACT.

SEC. 21054E. A HEALTH MAINTENANCE ORGANIZATION SHALL NOT ISSUE A MEDICARE SUPPLEMENTAL CONTRACT TO A PERSON WHO IS NOT ENROLLED IN PART A AND PART B OF THE FEDERAL MEDICARE PROGRAM. BEFORE ENROLLING A PERSON UNDER A NONGROUP MEDICARE SUPPLEMENTAL CONTRACT, THE HEALTH MAINTENANCE ORGANIZATION SHALL VERIFY THAT THE PERSON IS ENROLLED IN MEDICARE. A HEALTH MAINTENANCE ORGANIZATION SHALL REFUND ALL PREMIUMS RECEIVED FROM A PERSON FOR NONGROUP MEDICARE SUPPLEMENTAL COVERAGE, IF THE PERSON IS NOT ELIGIBLE FOR MEDICARE SUPPLEMENTAL COVERAGE. THE PERSON SHALL BE RESPONSIBLE FOR PAYMENT OF REASONABLE FEES FOR ANY HEALTH CARE SERVICES RECEIVED FROM THE ORGANIZATION PRIOR TO DETERMINATION THAT THE PERSON IS NOT ELIGIBLE BECAUSE HE OR SHE IS NOT ENROLLED IN MEDICARE.

SEC. 21054F. (1) BEFORE OFFERING A NONGROUP MEDICARE SUPPLEMENTAL CONTRACT TO AN APPLICANT, A HEALTH MAINTENANCE ORGANIZATION, OR A HEALTH BENEFIT AGENT OR ENROLLMENT REPRESENTATIVE ON BEHALF OF THE ORGANIZATION, SHALL INQUIRE WHETHER THE APPLICANT IS CURRENTLY A SUBSCRIBER UNDER A GROUP CONTRACT THAT PROVIDES SUBSTANTIALLY THE SAME BENEFITS AS THE NONGROUP CONTRACT AND SHALL NOTIFY THE APPLICANT HOW THE NONGROUP CONTRACT OFFERED BY THE ORGANIZATION WOULD DUPLICATE OR COORDINATE WITH THE EXISTING GROUP COVERAGE. THE RECEIPT OF NOTIFICATION REQUIRED UNDER THIS

SECTION SHALL BE ACKNOWLEDGED BY THE SIGNATURES OF THE APPLICANT AND THE HEALTH BENEFIT AGENT OR ENROLLMENT REPRESENTATIVE.

(2) IF EXISTING COVERAGE UNDER A HEALTH MAINTENANCE CONTRACT IS CONVERTED TO OR REPLACED BY A MEDICARE SUPPLEMENTAL CONTRACT WITH THE SAME ORGANIZATION, THE MEDICARE SUPPLEMENTAL CONTRACT SHALL NOT CONTAIN A PROVISION ESTABLISHING A NEW WAITING PERIOD EXCEPT WITH RESPECT TO AN INCREASE IN BENEFITS VOLUNTARILY SELECTED BY THE ENROLLEE.