SENATE BILL No. 309

April 13, 1989, Introduced by Senators CARL, POSTHUMUS and SHINKLE and referred to the Committee on Commerce and Technology.

A bill to amend sections 2265, 2273, and 2275 of Act No. 218 of the Public Acts of 1956, entitled as amended "The insurance code of 1956," section 2265 as amended and sections 2273 and 2275 as added by Act No. 195 of the Public Acts of 1982, being sections 500.2265, 500.2273, and 500.2275 of the Michigan Compiled Laws.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 2265, 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, being sections 500.2265, 500.2273, and 500.2275 of the Michigan Compiled Laws, are amended 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 ~~such~~ THE person would no longer be insured because he or she has become eligible for medicare or if ~~such~~ 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 ~~deductible and coinsurance requirements of part A and part B of the federal medicare program established by title XVIII of Public Law 89-97, 42 U.S.C. 1395c to 1395w, and in the case of a policy issued or renewed after the effective date of section 2272, which provides coverage of 90% of all medicare part A eligible expenses for hospitalization not covered by medicare, subject to a lifetime maximum benefit of an additional 365 days. However, a~~ 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. ~~Such~~ A person who wishes coverage under this subsection ~~must~~ 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 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 ~~such~~ 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. 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 ~~coinsurance~~ COPAYMENT requirements of part A and part B of the federal medicare program, ~~and coverage of 90% of all medicare part A eligible expenses for hospitalization not covered by medicare, subject to a lifetime maximum benefit of an additional 365 days~~ 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) ~~Upon request of the commissioner, each~~ 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, ~~a report of~~ 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) ~~All persons insured with existing medicare supplemental policies in effect at the effective date of this act shall be given the option of renewing their existing policies to include the benefits required by this act.~~ 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, 42 U.S.C. 1395u AND 1395ss, AND SHALL CERTIFY THAT COMPLIANCE ON THE MEDICARE SUPPLEMENT INSURANCE EXPERIENCE REPORTING FORM.

(4) AN INSURER SHALL NOT PROVIDE A COMMISSION OR OTHER COMPENSATION TO THE INSURER'S REPRESENTATIVE OR AGENT FOR THE SALE OR SERVICE OF A MEDICARE SUPPLEMENTAL POLICY THAT IS GREATER THAN THE RENEWAL COMMISSION OR COMPENSATION, IF THE EXISTING POLICY IS REPLACED BY ANOTHER POLICY WITH THE SAME INSURER OR ANY OF THE INSURER'S AFFILIATES, THE NEW POLICY BENEFITS ARE SUBSTANTIALLY SIMILAR TO THE BENEFITS UNDER THE REPLACED POLICY, AND THE REPLACED POLICY WAS ISSUED BY THE SAME INSURER OR ANY OF THE INSURER'S AFFILIATES.

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, ~~except~~ UNLESS THE BENEFITS ARE REQUIRED MINIMUM STANDARDS FOR MEDICARE SUPPLEMENTAL POLICIES OR if the increase in benefits or coverage is required by law. ~~Where~~ 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 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 ITS POLICYHOLDERS AND CERTIFICATE HOLDERS 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.