

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3819a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; minimum standards.

Sec. 3819a.

(1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010.

(2) An insurance policy must not be titled, advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter. An issuer shall not offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3819.

(3) The following standards apply to Medicare supplement policies:

(a) A Medicare supplement policy must not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate must 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 supplement policy must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy must 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(d) A Medicare supplement policy must be guaranteed renewable. Termination must be for nonpayment of premium or material misrepresentation only.

(e) Termination of a Medicare supplement policy must 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 on the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare part D benefits will not be considered in determining a continuous loss.

(f) A Medicare supplement policy must not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(4) A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Medicaid, but only if the policyholder or certificate holder notifies the insurer of the assistance within 90 days after the date the individual becomes entitled to the assistance. On receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under Medicaid, the policy must be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of Medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder if the policyholder is entitled to benefits under 42 USC 426(b), and is covered under a group health plan as defined in 42 USC 1395y(b)(1)(a)(v). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a Medicare supplement policy under this subsection:

(a) The reinstitution must not provide for any waiting period with respect to treatment of preexisting conditions.

(b) Reinstated coverage must be substantially equivalent to coverage in effect before the date of the suspension.

(c) Classification of premiums for reinstated coverage must be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

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