House
Legislative
Analysis
Section

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BCBSM MEDIGAP POLICIES

House Bill 4811 as introduced
First Analysis (6-2-93)

Sponsor: Rep. Gregory E. Pitoniak
Committee: Insurance

THE APPARENT PROBLEM:

Public Act 84 of 1992 amended the Insurance Code to incorporate federally mandated regulations governing Medicare supplemental (or "Medigap") policies. Those policies fill in some of the gaps in the federal Medicare program, the health insurance program mostly for people 65 years of age and older. Federal legislation requires that insurers sell no more than 10 standard policies, making it easier for consumers to shop for this kind of insurance. Over the years, there have been many complaints that the number and complexity of Medigap policies made shopping difficult (particularly when combined with deceptive and hard-sell marketing) and resulted in senior citizens not having coverage they thought they had or paying for duplicative policies (and sometimes both). The federal government requires that a state adopt the model legislation developed by the National Association of Insurance Commissioners (NAIC) if it wants to continue to be able to regulate the product; otherwise, the federal government would take over the task. Public Act 94 adopted the NAIC model for commercial insurance companies. The state also needs to adopt the same or similar legislation to cover the Medigap products marketed by Blue Cross and Blue Shield of Michigan and by health maintenance organizations (HMOs).

THE CONTENT OF THE BILL:

The bill would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1202 et al.), which regulates Blue Cross and Blue Shield of Michigan, to incorporate the provisions of the Medicare Supplement Insurance Minimum Standards Model Act of the National Association of Insurance Commissioners (NAIC). Similar provisions were placed into the Insurance Code by Public Act 84 of 1992 to apply to commercial insurance companies.

The following are among the elements of the bill.

* There would be ten permitted kinds of Medicare supplemental certificates that could be sold. One would contain the basic core package of benefits; the other nine would contain those benefits along with certain specified additional benefits. (Any new or innovative benefits beyond those specified would require the prior approval of the insurance commissioner.) The certificates would be identified by the letters A to J as designated in the bill. Blue Cross-Blue Shield would be required to offer a certificate ("A") containing the basic core of benefits and would be required to offer a Plan C certificate; the corporation could also offer the other eight kinds.

* The basic core package of benefits (making up all of Plan A and part of all other plans) would include:

-- coverage of Medicare-eligible hospitalization expenses from the 61st through the 90th day in any benefit period (currently $157 per day that otherwise would be due from the patient);

-- coverage of hospitalization expenses for each Medicare lifetime inpatient reserve day used (currently $314 per day);

-- coverage of hospitalization expenses upon exhaustion of hospital inpatient coverage, including lifetime reserve days, subject to a maximum benefit of an additional 365 days;

-- coverage under Parts A (hospitalization insurance) and B (medical insurance) for the reasonable costs of the first three pints of blood or equivalent quantities of red blood cells; and

-- coverage for the coinsurance amount under Part B (20 percent of approved costs) regardless of hospital confinement, subject to the Part B deductible (currently $100).

Benefit Plan B would include only the core benefits plus the Part A deductible (currently $628).

Benefit Plan C would include the Part A deductible, skilled nursing facility care, the Part B deductible ($100), and medically necessary emergency care in a foreign country.

Benefit Plan D would include the Part A deductible, skilled nursing facility care, emergency care in a foreign country, and the at-home recovery benefit.

Benefit Plan E would include the Part A deductible, skilled nursing facility care, emergency care in a foreign country, and preventive medical care.

Plan F would include the Part A deductible, skilled nursing facility care, the Part B deductible, 100 percent of Part B excess charges (i.e., the cost of a service above that for which Medicare will pay), and foreign emergency care.

Plan G would include the Part A deductible, skilled nursing facility care, 80 percent of Part B excess charges, foreign emergency care, and the at-home recovery benefit.

Plan H would include the Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and foreign emergency care.

Plan I would include the Part A deductible, skilled nursing facility care, 100 percent of Part B excess charges, the basic outpatient prescription drug benefit, foreign emergency care, and the at-home recovery benefit.

Plan J would include the Part A deductible, skilled nursing facility care, the Part B deductible, 100 percent of Part B excess charges, an extended outpatient prescription drug benefit, foreign emergency care, preventive medical care, and the at-home recovery benefit.

The benefits contained in a certificate would have to be as defined in the bill. The bill also contains definitions of key terms to be used in certificates.

* The bill contains an updated version of the form to be followed by an outline of coverage for a benefit plan; such an outline must be provided to an applicant at the time of application (and the corporation must obtain an acknowledgment of receipt of the outline, unless the certificate was a direct response solicitation certificate).

* The bill would also regulate Medicare select certificates. These are defined as supplemental certificates that contain "restricted network provisions." Such provisions condition the payment of benefits, in whole or in part, on the use of network providers within a given service area. A corporation could not issue such a certificate unless its plan of operation as a Medicare select health care corporation had been approved by the insurance commissioner. The plan of operation would have to contain, among other things, evidence that all covered services subject to restricted network provisions were available and accessible through network providers, descriptions of the service area, the grievance procedure, and the quality assurance program, and copies of the outlines of coverage to be provided to applicants. When the corporation offered a select certificate, it would have to offer the customer at the same time the opportunity to purchase any of its other Medicare supplement certificates and would have to offer a certificate with comparable or lesser benefits to a person covered under a select certificate. Select certificates would have to provide for continuation of coverage if select certificates were discontinued pursuant to determinations at the federal level.

* The bill would incorporate into the Nonprofit Health Care Corporation Act a set of marketing standards (also federally mandated) that have already been a part of the Insurance Code since Public Act 170 of 1990. These require, among other things, the fair and accurate comparison of policies for customers, require that any existing coverage be identified before new coverage is sold, prohibit the sale of excessive and duplicative coverage, and require that when new supplemental coverage replaces existing coverage, the new coverage waive all waiting periods and similar restrictions.

* The bill would provide, generally, that coverage under a Medicare supplemental certificate would be suspended (and premiums refunded) when a covered person became eligible for Medicaid and could be reinstituted later.

* If an application for a supplemental certificate is made during the six-month period after a person 65 years of age or older enrolls for benefits under Medicare Part B, the health care corporation could not deny or condition the issuance or effectiveness of a supplemental certificate, or discriminate in the pricing of the certificate, because of the health

status, claims experience, receipt of health care, or medical condition of the applicant.

FISCAL IMPLICATIONS:

The bill has no fiscal implications to the state, according to the Insurance Bureau. (6-1-93)

ARGUMENTS:

For:

The bill would apply to Blue Cross and Blue Shield of Michigan the same regulations regarding Medigap policies that apply to commercial health insurers. The adoption of legislation in this form is required by federal law if a state is to continue to regulate this product. The new provisions aim at making it easier for consumers to shop for Medicare supplemental policies by limiting the types of policies that can be sold, the provisions they can contain, and how they can be marketed.

POSITIONS:

A representative of the Insurance Bureau testified on behalf of the bill. (5-27-93)