MEMORANDUM

The Honorable Marvin L. Abney
Chairman, House Finance Committee

To:

The Honorable William J. Conley, R.
Chairman, Senate Finance Committee

From: Thomas A. Mullaney
Executive Director/State Budget Officer

Date: November 2, 2020


The Governor requests that a new article, entitled “Relating to Medicare Supplement Insurance Policies” be included in the FY 2021 Appropriations Act. This article would require insurance carriers to offer a Medicare Supplement Plan (“Medi-gap”) to Medicare beneficiaries who are eligible because of disability, versus age. Currently, insurers can exclude coverage based on pre-existing conditions and for some insurers to not offer coverage to disabled persons. Rhode Island is currently the only state in New England which does not require Medicare Supplement plans to be offered to any person eligible for Medicare, regardless of disability. RI has more than 51,000 persons purchasing Medicare Supplement products who will benefit from this budget amendment.

Blue Cross and Blue Shield of Rhode Island (“BCBSRI”) is the only plan in Rhode Island that offers “Plan A”, which is designed specifically and exclusively for disabled Medicare persons under age 65. The Office of the Health Insurance Commissioner (“OHIC”) has required BCBSRI to offer this product as the only Supplement available to disabled Rhode Islanders who are on Medicare but are not eligible for Medicaid. The rates for this product have escalated in recent years, increasing an average of 25% from 2020 to 2021.

During the COVID-19 pandemic, many of the individuals enrolled in this product have suffered financially, and struggle to maintain their health coverage. The provisions of this amendment will allow for increased access to a choice of products and the assurance that no one will be denied due to a pre-existing condition. Passage of this amendment now will impact products offered during Open Enrollment at this time next year.

Summary of Legislative Changes Contained in this Article:

- § 27-18.2-1(d)- changes director to the health insurance commissioner as it relates to the current jurisdiction to enforce these provisions.

- § 27-18.2-12- the additions under this section address OHIC’s concerns as it relates to:
  a. Persons Provided Continuity of Coverage: allows that anyone eligible for Medicare, regardless of the reason/disability, to seek a new Medicare Supplement policy with less or similar benefits,
if that person has had credible coverage for longer than 90 days. This provision also applies to members seeking coverage from a different carrier.

b. **Prohibition Against Discontinuity:** there shall be no medical underwriting for Persons Provided Continuity of Coverage as stated above.

c. **Determination of Benefits:** Issuers of the prior plan as described above, shall furnish any necessary information to the succeeding insurer as it relates to the verification of the benefits available when determination of benefits under the prior policy is required.

- **§ 27-18.2-13. Coverage of persons with disabilities:** This provision would require all Medicare Supplement carriers in the State of Rhode Island to offer their Plan A to all individuals who are entitled to Medicare, regardless of age or disability status. This provision also contains protections surrounding guaranteed issue and open enrollment. This addition addresses the immediate concerns of the state as they relate to the lack of Medicare Supplement options and protections for Rhode Island residents who are eligible for Medicare by reason of disability.

- **§ 27-18.2-14. Annual guaranteed issue period:** Requires that all carriers have a guaranteed issue period of at least one month per calendar year. This open enrollment period would require that all carriers offer their Plan A to all applicants, and cannot deny coverage to individual or group based on health status, claims experience, etc.

- **Effective on January 1, 2022.** If this bill is passed in 2020, health insurers (“issuers”) will develop and submit proposed plans to sell to Medicare beneficiaries in conformance with these provisions beginning in April of 2021. These plans and rates will be reviewed and approved for sale in the October-December 2021 Medicare Open Enrollment Period, with coverage effective on January 1, 2022.

After January 1, 2022, all issuers must be in compliance with the law, necessitating plans to be submitted to and approved by OHIC by summer of 2021, to be marketed to subscribers late in 2021.

Please contact Marie Ganim, Health Insurance Commissioner, at 462-9638 with any specific questions about this article.

Thank you.

Attachment

TAM: 21-Amend-18

Cc: Sharon Reynolds Ferland, House Fiscal Advisor
    Stephen Whitney, Senate Fiscal Advisor
    Marie Ganim, Health Insurance Commissioner
ARTICLE XX

RELATING TO MEDICARE SUPPLEMENT INSURANCE POLICIES

SECTION 1. Section 27-18.2-1 of the General Laws in Chapter 27-18.2 entitled "Medicare Supplement Insurance Policies" is hereby amended to read as follows:

27-18.2-1. Definitions.

(a) "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) In the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means, for the purposes of this chapter, any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Director" means the health insurance commissioner for the office of the health insurance commissioner.

(e) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(f) "Medicare" means the "Health Insurance for the Aged Act," 42 U.S.C. § 1395 et seq.

(g) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance, as defined in § 27-18-1, or a subscriber contract of a nonprofit hospital service corporation or of a nonprofit medical service corporation or an evidence of coverage of a health maintenance organization as defined in § 42-62-4(5) or as licensed under chapter 41 of this title, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. § 1395mm, or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which
is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for
the hospital, medical or surgical expenses of persons eligible for Medicare.

(h) "Policy form" means the form on which the policy is delivered or issued for delivery by the
issuer.

Policies” is hereby amended by adding thereto the following sections:

27-18.2-12. Continuity of coverage.

(a) Persons Provided Continuity of Coverage. The issuer shall provide continuity of coverage
for a person who has a Medicare supplement policy and seeks coverage under a new Medicare
supplement policy with the same or lesser benefits if that person, including a person entitled to Medicare
benefits due to disability, has been covered under a policy that supplemented benefits under Medicare
with no gap in coverage greater than 90 days beginning with the person’s open enrollment period. A
policy supplementing benefits payable under Medicare may include an individual health policy, a group
health plan, a Medicare supplement policy or other coverage issued by the same or a different carrier.

(b) Prohibition Against Discontinuity. The issuer shall, for any person described in subsection
a, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would
have been payable under the prior Medicare supplement policy and any earlier Medicare supplement
policy if those policies were still in effect. This subsection does not require the succeeding issuer to pay
any benefits that are not within the terms of coverage of the succeeding policy solely because they would
have been paid by the prior policy.

(c) Determination of Benefits. When a determination of benefits under the prior policy is
required, the issuer of the prior policy shall, at the request of the issuer of the succeeding policy, furnish
a statement of benefits available or pertinent information sufficient to permit verification of the benefit
determination or the determination itself by the issuer of the succeeding policy. For purposes of this
section, benefits of the prior policy are determined in accordance with the definitions, conditions and
covered expense provisions of that policy rather than those of the succeeding policy. The benefit
determination must be made as if coverage had not been replaced.
(d) Rulemaking. The director may adopt rules concerning guaranteed issuance and continuity
of Medicare supplement policies for certain eligible persons.

27-18.2-13. Coverage of the disabled

An issuer offering coverage under a Medicare supplement policy in this state shall offer
standardized Medicare Supplement Plan A coverage to all individuals, regardless of age, who are
entitled to Medicare benefits due to disability, and are enrolled in Medicare Part B. An issuer shall offer
such coverage during an individual’s open enrollment period during the first six (6) months immediately
following the applicant’s enrollment in Medicare Part B. An issuer shall also offer standardized
Medicare Supplement Plan A to persons entitled to Medicare benefits due to disability during the
guaranteed issue period as set forth in section 27-18.2-14. An individual who is entitled to Medicare
benefits due to disability must be provided continuity of coverage in accordance with section 27-18.2-
12. Issuers shall give notice of Medicare supplement coverage to individuals enrolled in Medicare in
advertising of Medicare supplement policies intended for use in this State. The director may establish
rules to ensure that the notice of the availability of coverage for the disabled is sufficiently advertised.


During a guaranteed issue period of at least one month each calendar year, as established by the
issuer, every issuer shall offer standardized Medicare Supplement Plan A to all applicants on a basis
that does not deny coverage to any individual or group based on health status, claims experience, receipt
of health care, or medical condition.

SECTION 3. This Article shall take effect on January 1, 2022.