

104TH CONGRESS
2D SESSION

S. 2075

To amend title XVIII of the Social Security Act to provide additional consumer protections for medicare supplemental insurance.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 16, 1996

Mr. CHAFEE (for himself and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide additional consumer protections for medicare supplemental insurance.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medigap Portability
5 Act of 1996”.

6 **SEC. 2. MEDIGAP AMENDMENTS.**

7 (a) GUARANTEEING ISSUE WITHOUT PREEXISTING
8 CONDITIONS FOR CONTINUOUSLY COVERED INDIVID-
9 UALS.—Section 1882(s) of the Social Security Act (42
10 U.S.C. 1395ss(s)) is amended—

1 (1) in paragraph (3), by striking “paragraphs
2 (1) and (2)” and inserting “this subsection”,

3 (2) by redesignating paragraph (3) as para-
4 graph (4), and

5 (3) by inserting after paragraph (2) the follow-
6 ing new paragraph:

7 “(3)(A) The issuer of a medicare supplemental pol-
8 icy—

9 “(i) may not deny or condition the issuance or
10 effectiveness of a medicare supplemental policy de-
11 scribed in subparagraph (C);

12 “(ii) may not discriminate in the pricing of the
13 policy on the basis of the individual’s health status,
14 medical condition (including both physical and men-
15 tal illnesses), claims experience, receipt of health
16 care, medical history, genetic information, evidence
17 of insurability (including conditions arising out of
18 acts of domestic violence), or disability; and

19 “(iii) may not impose an exclusion of benefits
20 based on a pre-existing condition,

21 in the case of an individual described in subparagraph (B)
22 who seeks to enroll under the policy not later than 63 days
23 after the date of the termination of enrollment described
24 in such subparagraph.

1 “(B) An individual described in this subparagraph is
2 an individual described in any of the following clauses:

3 “(i) The individual is enrolled with an eligible
4 organization under a contract under section 1876 or
5 with an organization under an agreement under sec-
6 tion 1833(a)(1)(A) and such enrollment ceases ei-
7 ther because the individual moves outside the service
8 area of the organization under the contract or agree-
9 ment or because of the termination or nonrenewal of
10 the contract or agreement.

11 “(ii) The individual is enrolled with an organi-
12 zation under a policy described in subsection (t) and
13 such enrollment ceases either because the individual
14 moves outside the service area of the organization
15 under the policy, because of the bankruptcy or insol-
16 vency of the insurer, or because the insurer closes
17 the block of business to new enrollment.

18 “(iii) The individual is covered under a medi-
19 care supplemental policy and such coverage is termi-
20 nated because of the bankruptcy or insolvency of the
21 insurer issuing the policy, because the insurer closes
22 the block of business to new enrollment, or because
23 the individual changes residence so that the individ-
24 ual no longer resides in a State in which the issuer
25 of the policy is licensed.

1 “(iv) The individual is enrolled under an em-
2 ployee welfare benefit plan that provides health ben-
3 efits that supplement the benefits under this title
4 and the plan terminates or ceases to provide (or sig-
5 nificantly reduces) such supplemental health benefits
6 to the individual.

7 “(v)(I) The individual is enrolled with an eligi-
8 ble organization under a contract under section
9 1876 or with an organization under an agreement
10 under section 1833(a)(1)(A) and such enrollment is
11 terminated by the enrollee during the first 12
12 months of such enrollment, but only if the individual
13 never was previously enrolled with an eligible organi-
14 zation under a contract under section 1876 or with
15 an organization under an agreement under section
16 1833(a)(1)(A).

17 “(II) The individual is enrolled under a policy
18 described in subsection (t) and such enrollment is
19 terminated during the first 12 months of such en-
20 rollment, but only if the individual never was pre-
21 viously enrolled under such a policy under such sub-
22 section.

23 “(C)(i) Subject to clause (ii), a medicare supple-
24 mental policy described in this subparagraph, with respect
25 to an individual described in subparagraph (B), is a policy

1 the benefits under which are comparable or lesser in rela-
2 tion to the benefits under the enrollment described in sub-
3 paragraph (B) (or, in the case of an individual described
4 in clause (ii), under the most recent medicare supple-
5 mental policy described in clause (ii)(II)).

6 “(ii) An individual described in this clause is an indi-
7 vidual who—

8 “(I) is described in subparagraph (B)(v), and

9 “(II) was enrolled in a medicare supplemental
10 policy within the 63 day period before the enrollment
11 described in such subparagraph.

12 “(iii) As a condition for approval of a State regu-
13 latory program under subsection (b)(1) and for purposes
14 of applying clause (i) to policies to be issued in the State,
15 the regulatory program shall provide for the method of
16 determining whether policy benefits are comparable or
17 lesser in relation to other benefits. With respect to a State
18 without such an approved program, the Secretary shall es-
19 tablish such method.

20 “(D) At the time of an event described in subpara-
21 graph (B) because of which an individual ceases enroll-
22 ment or loses coverage or benefits under a contract or
23 agreement, policy, or plan, the organization that offers the
24 contract or agreement, the insurer offering the policy, or
25 the administrator of the plan, respectively, shall notify the

1 individual of the rights of the individual, and obligations
2 of issuers of medicare supplemental policies, under sub-
3 paragraph (A).”.

4 (b) LIMITATION ON IMPOSITION OF PREEXISTING
5 CONDITION EXCLUSION DURING INITIAL OPEN ENROLL-
6 MENT PERIOD.—Section 1882(s)(2)(B) of such Act (42
7 U.S.C. 1395ss(s)(2)(B)) is amended to read as follows:

8 “(B) In the case of a policy issued during the 6-
9 month period described in subparagraph (A), the policy
10 may not exclude benefits based on a pre-existing condi-
11 tion.”.

12 (c) CLARIFYING THE NONDISCRIMINATION REQUIRE-
13 MENTS DURING THE 6-MONTH INITIAL ENROLLMENT
14 PERIOD.—Section 1882(s)(2)(A) of such Act (42 U.S.C.
15 1395ss(s)(2)(A)) is amended to read as follows:

16 “(2)(A)(i) In the case of an individual described in
17 clause (ii), the issuer of a medicare supplemental policy—

18 “(I) may not deny or condition the issuance or
19 effectiveness of a medicare supplemental policy, and

20 “(II) may not discriminate in the pricing of the
21 policy on the basis of the individual’s health status,
22 medical condition (including both physical and men-
23 tal illnesses), claims experience, receipt of health
24 care, medical history, genetic information, evidence

1 of insurability (including conditions arising out of
2 acts of domestic violence), or disability.

3 “(ii) An individual described in this clause is an indi-
4 vidual for whom an application is submitted before the end
5 of the 6-month period beginning with the first month as
6 of the first day on which the individual is 65 years of age
7 or older and is enrolled for benefits under part B.”.

8 (d) EXTENDING 6-MONTH INITIAL ENROLLMENT
9 PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—
10 Section 1882(s)(2)(A)(ii) of such Act (42 U.S.C.
11 1395ss(s)(2)(A)), as amended by subsection (c), is amend-
12 ed by striking “is submitted” and all that follows and in-
13 serting the following: “is submitted—

14 “(I) before the end of the 6-month period be-
15 ginning with the first month as of the first day on
16 which the individual is 65 years of age or older and
17 is enrolled for benefits under part B; and

18 “(II) for each time the individual becomes eligi-
19 ble for benefits under part A pursuant to section
20 226(b) or 226A and is enrolled for benefits under
21 part B, before the end of the 6-month period begin-
22 ning with the first month as of the first day on
23 which the individual is so eligible and so enrolled.”.

24 (e) EFFECTIVE DATES.—

1 (1) GUARANTEED ISSUE.—The amendment
2 made by subsection (a) shall take effect on July 1,
3 1997.

4 (2) LIMIT ON PREEXISTING CONDITION EXCLU-
5 SIONS.—The amendment made by subsection (b)
6 shall apply to policies issued on or after July 1,
7 1997.

8 (3) CLARIFICATION OF NONDISCRIMINATION
9 REQUIREMENTS.—The amendment made by sub-
10 section (c) shall apply to policies issued on or after
11 July 1, 1997.

12 (4) EXTENSION OF ENROLLMENT PERIOD TO
13 DISABLED INDIVIDUALS.—

14 (A) IN GENERAL.—The amendment made
15 by subsection (d) shall take effect on July 1,
16 1997.

17 (B) TRANSITION RULE.—In the case of an
18 individual who first became eligible for benefits
19 under part A of title XVIII of the Social Secu-
20 rity Act pursuant to section 226(b) or 226A of
21 such Act and enrolled for benefits under part B
22 of such title before July 1, 1997, the 6-month
23 period described in section 1882(s)(2)(A) of
24 such Act shall begin on July 1, 1997. Before
25 July 1, 1997, the Secretary of Health and

1 Human Services shall notify any individual de-
2 scribed in the previous sentence of their rights
3 in connection with medicare supplemental poli-
4 cies under section 1882 of such Act, by reason
5 of the amendment made by subsection (d).

6 (f) TRANSITION PROVISIONS.—

7 (1) IN GENERAL.—If the Secretary of Health
8 and Human Services identifies a State as requiring
9 a change to its statutes or regulations to conform its
10 regulatory program to the changes made by this sec-
11 tion, the State regulatory program shall not be con-
12 sidered to be out of compliance with the require-
13 ments of section 1882 of the Social Security Act due
14 solely to failure to make such change until the date
15 specified in paragraph (4).

16 (2) NAIC STANDARDS.—If, within 9 months
17 after the date of the enactment of this Act, the Na-
18 tional Association of Insurance Commissioners (in
19 this subsection referred to as the “NAIC”) modifies
20 its NAIC Model Regulation relating to section 1882
21 of the Social Security Act (referred to in such sec-
22 tion as the 1991 NAIC Model Regulation, as modi-
23 fied pursuant to section 171(m)(2) of the Social Se-
24 curity Act Amendments of 1994 (Public Law 103–
25 432) and as modified pursuant to section

1 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as
2 added by section 271(a) of the Health Care Port-
3 ability and Accountability Act of 1996 (Public Law
4 104–191) to conform to the amendments made by
5 this section, such revised regulation incorporating
6 the modifications shall be considered to be the appli-
7 cable NAIC model regulation (including the revised
8 NAIC model regulation and the 1991 NAIC Model
9 Regulation) for the purposes of such section.

10 (3) SECRETARY STANDARDS.—If the NAIC
11 does not make the modifications described in para-
12 graph (2) within the period specified in such para-
13 graph, the Secretary of Health and Human Services
14 shall make the modifications described in such para-
15 graph and such revised regulation incorporating the
16 modifications shall be considered to be the appro-
17 priate Regulation for the purposes of such section.

18 (4) DATE SPECIFIED.—

19 (A) IN GENERAL.—Subject to subpara-
20 graph (B), the date specified in this paragraph
21 for a State is the earlier of—

22 (i) the date the State changes its stat-
23 utes or regulations to conform its regu-
24 latory program to the changes made by
25 this section, or

1 (ii) 1 year after the date the NAIC or
 2 the Secretary first makes the modifications
 3 under paragraph (2) or (3), respectively.

4 (B) ADDITIONAL LEGISLATIVE ACTION RE-
 5 QUIRED.—In the case of a State which the Sec-
 6 retary identifies as—

7 (i) requiring State legislation (other
 8 than legislation appropriating funds) to
 9 conform its regulatory program to the
 10 changes made in this section, but

11 (ii) having a legislature which is not
 12 scheduled to meet in 1998 in a legislative
 13 session in which such legislation may be
 14 considered,

15 the date specified in this paragraph is the first
 16 day of the first calendar quarter beginning after
 17 the close of the first legislative session of the
 18 State legislature that begins on or after July 1,
 19 1998. For purposes of the previous sentence, in
 20 the case of a State that has a 2-year legislative
 21 session, each year of such session shall be
 22 deemed to be a separate regular session of the
 23 State legislature.

24 **SEC. 3. INFORMATION FOR MEDICARE BENEFICIARIES.**

25 (a) GRANT PROGRAM.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (in this section referred to as the
3 “Secretary”) is authorized to provide grants to—

4 (A) private, independent, non-profit
5 consumer organizations, and

6 (B) State agencies,

7 to conduct programs to prepare and make available
8 to medicare beneficiaries comprehensive and under-
9 standable information on enrollment in health plans
10 with a medicare managed care contract and in medi-
11 care supplemental policies in which they are eligible
12 to enroll. Nothing in this section shall be construed
13 as preventing the Secretary from making a grant to
14 an organization under this section to carry out ac-
15 tivities for which a grant may be made under section
16 4360 of the Omnibus Budget Reconciliation Act of
17 1990 (Public Law 101–508).

18 (2) CONSUMER SATISFACTION SURVEYS.—Any
19 eligible organization with a medicare managed care
20 contract or any issuer of a medicare supplemental
21 policy shall—

22 (A) conduct, in accordance with minimum
23 standards approved by the Secretary, a
24 consumer satisfaction survey of the enrollees
25 under such contract or such policy; and

1 (B) make the results of such survey avail-
2 able to the Secretary and the State Insurance
3 Commissioner of the State in which the enroll-
4 ees are so enrolled.

5 The Secretary shall make the results of such surveys
6 available to organizations which receive grants under
7 paragraph (1).

8 (3) INFORMATION.—

9 (A) CONTENTS.—The information de-
10 scribed in paragraph (1) shall include at least
11 a comparison of such contracts and policies, in-
12 cluding a comparison of the benefits provided,
13 quality and performance, the costs to enrollees,
14 the results of consumer satisfaction surveys on
15 such contracts and policies, as described in sub-
16 section (a)(2), and such additional information
17 as the Secretary may prescribe.

18 (B) INFORMATION STANDARDS.—The Sec-
19 retary shall develop standards and criteria to
20 ensure that the information provided to medi-
21 care beneficiaries under a grant under this sec-
22 tion is complete, accurate, and uniform.

23 (C) REVIEW OF INFORMATION.—The Sec-
24 retary may prescribe the procedures and condi-
25 tions under which an organization that has ob-

1 tained a grant under this section may furnish
2 information obtained under the grant to medi-
3 care beneficiaries. Such information shall be
4 submitted to the Secretary at least 45 days be-
5 fore the date the information is first furnished
6 to such beneficiaries.

7 (4) CONSULTATION WITH OTHER ORGANIZA-
8 TIONS AND PROVIDERS.—An organization which re-
9 ceives a grant under paragraph (1) shall consult
10 with private insurers, managed care plan providers
11 and other health care providers, and public and pri-
12 vate purchasers of health care benefits in order to
13 provide the information described in paragraph (1).

14 (5) TERMS AND CONDITIONS.—To be eligible
15 for a grant under this section, an organization shall
16 prepare and submit to the Secretary an application
17 at such time, in such form, and containing such in-
18 formation as the Secretary may require. Grants
19 made under this section shall be in accordance with
20 terms and conditions specified by the Secretary.

21 (b) COST-SHARING.—

22 (1) IN GENERAL.—Each organization which
23 provides a medicare managed care contract or issues
24 a medicare supplemental policy (including a medi-
25 care select policy) shall pay to the Secretary its pro

1 rata share (as determined by the Secretary) of the
2 estimated costs to be incurred by the Secretary in
3 providing the grants described in subsection (a).

4 (2) LIMITATION.—The total amount required to
5 be paid under paragraph (1) shall not exceed
6 \$35,000,000 in any fiscal year.

7 (3) APPLICATION OF PROCEEDS.—Amounts re-
8 ceived under paragraph (1) are hereby appropriated
9 to the Secretary to defray the costs described in
10 such paragraph and shall remain available until ex-
11 pended.

12 (c) DEFINITIONS.—In this section:

13 (1) MEDICARE MANAGED CARE CONTRACT.—
14 The term “medicare managed care contract” means
15 a contract under section 1876 or section
16 1833(a)(1)(A) of the Social Security Act.

17 (2) MEDICARE SUPPLEMENTAL POLICY.—The
18 term “medicare supplemental policy” has the mean-
19 ing given such term in section 1882(g) of the Social
20 Security Act.

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