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105TH CONGRESS
1ST SESSION

# H. R. 625

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

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IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1997

Mrs. JOHNSON of Connecticut (for herself, Mr. DINGELL, Mr. GREENWOOD, Mr. STARK, Mr. SHAW, Mr. CARDIN, Mr. SAXTON, Mr. PALLONE, Mr. DEFAZIO, Mr. MCDERMOTT, Mr. KLECZKA, Mr. RAHALL, Mr. ACKERMAN, Mr. HILLIARD, Mr. COBURN, Ms. PELOSI, Mr. BORSKI, Mr. ENSIGN, Mr. LEACH, Mr. DEUTSCH, Mr. GORDON, Mr. WAXMAN, Mrs. THURMAN, Mr. MILLER of California, Ms. SLAUGHTER, Mr. OLVER, Mr. DELLUMS, Ms. LOFGREN, Mr. SHAYS, Mr. FOGLIETTA, Mr. NEY, Mr. NADLER, Mrs. CLAYTON, Mr. TOWNS, Mr. SAWYER, Mr. KLINK, Mr. RUSH, Mr. STUPAK, Mr. LAFALCE, Mr. FRANK of Massachusetts, Ms. ESHOO, Mr. BROWN of Ohio, Mr. GREEN, Ms. FURSE, Mr. ENGEL, Mr. MARKEY, Mr. STRICKLAND, Mr. FROST, Mr. BOUCHER, Ms. DEGETTE, and Mr. MANTON) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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# A BILL

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

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Medigap Amendments of 1997''.

**SEC. 2. MEDIGAP AMENDMENTS.**

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)) is amended—

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

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following new paragraph:

''(3)(A) The issuer of a Medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a Medicare supplemental policy described in subparagraph (C);

''(ii) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability; and

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

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

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

''(i) The individual is enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A) and such enrollment ceases either because the individual moves outside the service area of the organization under the contract or agreement or because of the termination or nonrenewal of the contract or agreement.

''(ii) The individual is enrolled with an organization under a policy described in subsection (t) and such enrollment ceases either because the individual moves outside the service area of the organization under the policy, because of the bankruptcy or insolvency of the insurer, or because the insurer closes the block of business to new enrollment.

''(iii) The individual is covered under a Medicare supplemental policy and such coverage is terminated because of the bankruptcy or insolvency of the insurer issuing the policy, because the insurer closes the block of business to new enrollment, or because the individual changes residence so that the individual no longer resides in a State in which the issuer of the policy is licensed.

''(iv) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide (or significantly reduces) such supplemental health benefits to the individual.

''(v)(I) The individual is enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A) and such enrollment is terminated by the enrollee during the first 12 months of such enrollment, but only if the individual never was previously enrolled with an eligible organization under a contract under section 1876 or with an organization under an agreement under section 1833(a)(1)(A).

''(II) The individual is enrolled under a policy described in subsection (t) and such enrollment is terminated during the first 12 months of such enrollment, but only if the individual never was previously enrolled under such a policy under such subsection.

''(C)(i) Subject to clause (ii), a Medicare supplemental policy described in this subparagraph, with respect to an individual described in subparagraph (B), is a policy the benefits under which are comparable or lesser in relation to the benefits under the enrollment described in subparagraph (B) (or, in the case of an individual described in clause (ii), under the most recent Medicare supplemental policy described in clause (ii)(II)).

''(ii) An individual described in this clause is an individual who—

''(I) is described in subparagraph (B)(v), and

''(II) was enrolled in a Medicare supplemental policy within the 63 day period before the enrollment described in such subparagraph.

''(iii) As a condition for approval of a State regulatory program under subsection (b)(1) and for purposes of applying clause (i) to policies to be issued in the State, the regulatory program shall provide for the method of determining whether policy benefits are comparable or

lesser in relation to other benefits. With respect to a State without such an approved program, the Secretary shall establish such method.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of Medicare supplemental policies, under subparagraph (A).''.

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

''(B) In the case of a policy issued during the 6-month period described in subparagraph (A), the policy may not exclude benefits based on a pre-existing condition.''.

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

''(2)(A)(i) In the case of an individual described in clause (ii), the issuer of a Medicare supplemental policy—

''(I) may not deny or condition the issuance or effectiveness of a Medicare supplemental policy, and

''(II) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

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

(d) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of such Act (42 U.S.C. 1395ss(s)(2)(A)), as amended by subsection (c), is amended by striking ''is submitted'' and all that follows and inserting the following: ''is submitted—

''(I) before the end of the 6-month period beginning with the first month as of the first day on

which the individual is 65 years of age or older and is enrolled for benefits under part B; and

''(II) for each time the individual becomes eligible for benefits under part A pursuant to section 226(b) or 226A and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.''.

(e) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) CLARIFICATION OF NONDISCRIMINATION REQUIREMENTS.—The amendment made by subsection (c) shall apply to policies issued on or after July 1, 1998.

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

(A) IN GENERAL.—The amendment made by subsection (d) shall take effect on July 1, 1998.

(B) TRANSITION RULE.—In the case of an individual who first became eligible for benefits under part A of title XVIII of the Social Security Act pursuant to section 226(b) or 226A of such Act and enrolled for benefits under part B of such title before July 1, 1998, the 6-month period described in section 1882(s)(2)(A) of such Act shall begin on July 1, 1998. Before July 1, 1998, the Secretary of Health and Human Services shall notify any individual described in the previous sentence of their rights in connection with Medicare supplemental policies under section 1882 of such Act, by reason of the amendment made by subsection (d).

(f) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Care Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the

modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

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

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

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

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

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

(a) GRANT PROGRAM.—

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

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

(B) State agencies,

to conduct programs to prepare and make available to Medicare beneficiaries comprehensive and understandable information on enrollment in health plans with a Medicare managed care contract and in Medicare supplemental policies in which they are eligible to enroll. Nothing in this section shall be construed as preventing the Secretary from making a grant to

an organization under this section to carry out activities for which a grant may be made under section 4360 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508).

(2) CONSUMER SATISFACTION SURVEYS.—Any eligible organization with a Medicare managed care contract or any issuer of a Medicare supplemental policy shall—

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

(B) make the results of such survey available to Secretary and the State Insurance Commissioner of the State in which the enrollees are so enrolled.

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

(3) INFORMATION.—

(A) CONTENTS.—The information described in paragraph (1) shall include at least a comparison of such contracts and policies, including a comparison of the benefits provided, quality and performance, the costs to enrollees,

the results of consumer satisfaction surveys on such contracts and policies, as described in subsection (a)(2), and such additional information as the Secretary may prescribe.

(B) INFORMATION STANDARDS.—The Secretary shall develop standards and criteria to ensure that the information provided to Medicare beneficiaries under a grant under this section is complete, accurate, and uniform.

(C) REVIEW OF INFORMATION.—The Secretary may prescribe the procedures and conditions under which an organization that has obtained a grant under this section may furnish information obtained under the grant to Medicare beneficiaries. Such information shall be submitted to the Secretary at least 45 days before the date the information is first furnished to such beneficiaries.

(4) CONSULTATION WITH OTHER ORGANIZATIONS AND PROVIDERS.—An organization which receives a grant under paragraph (1) shall consult with private insurers, managed care plan providers and other health care providers, and public and private purchasers of health care benefits in order to provide the information described in paragraph (1).

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

(b) COST-SHARING.—

(1) IN GENERAL.—Each organization which provides a Medicare managed care contract or issues a Medicare supplemental policy (including a Medicare select policy) shall pay to the Secretary its pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in providing the grants described in subsection (a).

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

(3) APPLICATION OF PROCEEDS.—Amounts received under paragraph (1) are hereby appropriated to the Secretary to defray the costs described in such paragraph and shall remain available until expended.

(c) DEFINITIONS.—In this section:

(1) MEDICARE MANAGED CARE CONTRACT.—The term ''Medicare managed care contract'' means a contract under section 1876 or section 1833(a)(1)(A) of the Social Security Act.

(2) MEDICARE SUPPLEMENTAL POLICY.—The term ''Medicare supplemental policy'' has the meaning given such term in section 1882(g) of the Social Security Act.

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