

105TH CONGRESS
1ST SESSION

S. 302

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

FEBRUARY 11, 1997

Mr. CHAFEE (for himself, Mr. ROCKEFELLER, Mr. FRIST, Mr. JEFFORDS, and Ms. COLLINS) 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 1997”.

1 **SEC. 2. MEDIGAP AMENDMENTS.**

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

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

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

10 (3) by inserting after paragraph (2) the follow-
11 ing new paragraph:

12 “(3)(A) The issuer of a medicare supplemental pol-
13 icy—

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

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

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

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

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

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

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

22 “(iii) The individual is covered under a medi-
23 care supplemental policy and such coverage is termi-
24 nated because of the bankruptcy or insolvency of the
25 insurer issuing the policy, because the insurer closes

1 the block of business to new enrollment, or because
2 the individual changes residence so that the individ-
3 ual no longer resides in a State in which the issuer
4 of the policy is licensed.

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

11 “(v)(I) The individual is enrolled with an eligi-
12 ble organization under a contract under section
13 1876 or with an organization under an agreement
14 under section 1833(a)(1)(A) and such enrollment is
15 terminated by the enrollee during the first 12
16 months of such enrollment, but only if the individual
17 never was previously enrolled with an eligible organi-
18 zation under a contract under section 1876 or with
19 an organization under an agreement under section
20 1833(a)(1)(A).

21 “(II) The individual is enrolled under a policy
22 described in subsection (t) and such enrollment is

1 terminated during the first 12 months of such en-
2 rollment, but only if the individual never was pre-
3 viously enrolled under such a policy under such sub-
4 section.

5 “(C)(i) Subject to clause (ii), a medicare supple-
6 mental policy described in this subparagraph, with respect
7 to an individual described in subparagraph (B), is a policy
8 the benefits under which are comparable or lesser in rela-
9 tion to the benefits under the enrollment described in sub-
10 paragraph (B) (or, in the case of an individual described
11 in clause (ii), under the most recent medicare supple-
12 mental policy described in clause (ii)(II)).

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

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

16 “(II) was enrolled in a medicare supplemental
17 policy within the 63 day period before the enrollment
18 described in such subparagraph.

19 “(iii) As a condition for approval of a State regu-
20 latory program under subsection (b)(1) and for purposes
21 of applying clause (i) to policies to be issued in the State,
22 the regulatory program shall provide for the method of
23 determining whether policy benefits are comparable or
24 lesser in relation to other benefits. With respect to a State

1 without such an approved program, the Secretary shall es-
 2 tablish such method.

3 “(D) At the time of an event described in subpara-
 4 graph (B) because of which an individual ceases enroll-
 5 ment or loses coverage or benefits under a contract or
 6 agreement, policy, or plan, the organization that offers the
 7 contract or agreement, the insurer offering the policy, or
 8 the administrator of the plan, respectively, shall notify the
 9 individual of the rights of the individual, and obligations
 10 of issuers of medicare supplemental policies, under sub-
 11 paragraph (A).”.

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

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

20 (c) CLARIFYING THE NONDISCRIMINATION REQUIRE-
 21 MENTS DURING THE 6-MONTH INITIAL ENROLLMENT
 22 PERIOD.—Section 1882(s)(2)(A) of such Act (42 U.S.C.
 23 1395ss(s)(2)(A)) is amended to read as follows:

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

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

3 “(II) may not discriminate in the pricing of the
4 policy on the basis of the individual’s health status,
5 medical condition (including both physical and men-
6 tal illnesses), claims experience, receipt of health
7 care, medical history, genetic information, evidence
8 of insurability (including conditions arising out of
9 acts of domestic violence), or disability.

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

15 (d) EXTENDING 6-MONTH INITIAL ENROLLMENT
16 PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—
17 Section 1882(s)(2)(A)(ii) of such Act (42 U.S.C.
18 1395ss(s)(2)(A)), as amended by subsection (c), is amend-
19 ed by striking “is submitted” and all that follows and in-
20 serting the following: “is submitted—

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

1 “(II) for each time the individual becomes eligi-
2 ble for benefits under part A pursuant to section
3 226(b) or 226A and is enrolled for benefits under
4 part B, before the end of the 6-month period begin-
5 ning with the first month as of the first day on
6 which the individual is so eligible and so enrolled.”.

7 (e) EFFECTIVE DATES.—

8 (1) GUARANTEED ISSUE.—The amendment
9 made by subsection (a) shall take effect on January
10 1, 1998.

11 (2) LIMIT ON PREEXISTING CONDITION EXCLU-
12 SIONS.—The amendment made by subsection (b)
13 shall apply to policies issued on or after January 1,
14 1998.

15 (3) CLARIFICATION OF NONDISCRIMINATION
16 REQUIREMENTS.—The amendment made by sub-
17 section (c) shall apply to policies issued on or after
18 January 1, 1998.

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

21 (A) IN GENERAL.—The amendment made
22 by subsection (d) shall take effect on July 1,
23 1998.

24 (B) TRANSITION RULE.—In the case of an
25 individual who first became eligible for benefits

1 under part A of title XVIII of the Social Secu-
2 rity Act pursuant to section 226(b) or 226A of
3 such Act and enrolled for benefits under part B
4 of such title before July 1, 1998, the 6-month
5 period described in section 1882(s)(2)(A) of
6 such Act shall begin on July 1, 1998. Before
7 July 1, 1998, the Secretary of Health and
8 Human Services shall notify any individual de-
9 scribed in the previous sentence of their rights
10 in connection with medicare supplemental poli-
11 cies under section 1882 of such Act, by reason
12 of the amendment made by subsection (d).

13 (f) TRANSITION PROVISIONS.—

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

23 (2) NAIC STANDARDS.—If, within 9 months
24 after the date of the enactment of this Act, the Na-
25 tional Association of Insurance Commissioners (in

1 this subsection referred to as the “NAIC”) modifies
2 its NAIC model regulation relating to section 1882
3 of the Social Security Act (referred to in such sec-
4 tion as the 1991 NAIC Model Regulation, as modi-
5 fied pursuant to section 171(m)(2) of the Social Se-
6 curity Act Amendments of 1994 (Public Law 103-
7 432) and as modified pursuant to section
8 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as
9 added by section 271(a) of the Health Care Port-
10 ability and Accountability Act of 1996 (Public Law
11 104–191) to conform to the amendments made by
12 this section, such revised regulation incorporating
13 the modifications shall be considered to be the appli-
14 cable NAIC model regulation (including the revised
15 NAIC model regulation and the 1991 NAIC model
16 regulation) for the purposes of such section.

17 (3) SECRETARY STANDARDS.—If the NAIC
18 does not make the modifications described in para-
19 graph (2) within the period specified in such para-
20 graph, the Secretary of Health and Human Services
21 shall make the modifications described in such para-
22 graph and such revised regulation incorporating the
23 modifications shall be considered to be the appro-
24 priate regulation for the purposes of such section.

25 (4) DATE SPECIFIED.—

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

4 (i) the date the State changes its stat-
5 utes or regulations to conform its regu-
6 latory program to the changes made by
7 this section, or

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

11 (B) ADDITIONAL LEGISLATIVE ACTION RE-
12 QUIRED.—In the case of a State which the Sec-
13 retary identifies as—

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

18 (ii) having a legislature which is not
19 scheduled to meet in the calendar year in
20 which the modifications under paragraph
21 (2) or (3) are made in a legislative session
22 in which such legislation may be consid-
23 ered,

24 the date specified in this paragraph is the first
25 day of the first calendar quarter beginning after

1 the close of the first legislative session of the
2 State legislature that begins on or after July 1
3 of the calendar year referred to in clause (ii).
4 For purposes of the previous sentence, in the
5 case of a State that has a 2-year legislative ses-
6 sion, each year of such session shall be deemed
7 to be a separate regular session of the State
8 legislature.

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

10 (a) GRANT PROGRAM.—

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

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

16 (B) State agencies,

17 to conduct programs to prepare and make available
18 to medicare beneficiaries comprehensive and under-
19 standable information on enrollment in health plans
20 with a medicare managed care contract and in medi-
21 care supplemental policies in which they are eligible
22 to enroll. Nothing in this section shall be construed
23 as preventing the Secretary from making a grant to
24 an organization under this section to carry out ac-
25 tivities for which a grant may be made under section

1 4360 of the Omnibus Budget Reconciliation Act of
2 1990 (Public Law 101–508).

3 (2) CONSUMER SATISFACTION SURVEYS.—Any
4 eligible organization with a medicare managed care
5 contract or any issuer of a medicare supplemental
6 policy shall—

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

11 (B) make the results of such survey avail-
12 able to the Secretary and the State Insurance
13 Commissioner of the State in which the enroll-
14 ees are so enrolled.

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

18 (3) INFORMATION.—

19 (A) CONTENTS.—The information de-
20 scribed in paragraph (1) shall include at least
21 a comparison of such contracts and policies, in-
22 cluding a comparison of the benefits provided,
23 quality and performance, the costs to enrollees,
24 the results of consumer satisfaction surveys on

1 such contracts and policies, as described in sub-
2 section (a)(2), and such additional information
3 as the Secretary may prescribe.

4 (B) INFORMATION STANDARDS.—The Sec-
5 retary shall develop standards and criteria to
6 ensure that the information provided to medi-
7 care beneficiaries under a grant under this sec-
8 tion is complete, accurate, and uniform.

9 (C) REVIEW OF INFORMATION.—The Sec-
10 retary may prescribe the procedures and condi-
11 tions under which an organization that has ob-
12 tained a grant under this section may furnish
13 information obtained under the grant to medi-
14 care beneficiaries. Such information shall be
15 submitted to the Secretary at least 45 days be-
16 fore the date the information is first furnished
17 to such beneficiaries.

18 (4) CONSULTATION WITH OTHER ORGANIZA-
19 TIONS AND PROVIDERS.—An organization which re-
20 ceives a grant under paragraph (1) shall consult
21 with private insurers, managed care plan providers
22 and other health care providers, and public and pri-
23 vate purchasers of health care benefits in order to
24 provide the information described in paragraph (1).

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

8 (b) COST-SHARING.—

9 (1) IN GENERAL.—Each organization which
10 provides a medicare managed care contract or issues
11 a medicare supplemental policy (including a medi-
12 care select policy) shall pay to the Secretary its pro
13 rata share (as determined by the Secretary) of the
14 estimated costs to be incurred by the Secretary in
15 providing the grants described in subsection (a).

16 (2) LIMITATION.—The total amount required to
17 be paid under paragraph (1) shall not exceed
18 \$35,000,000 in any fiscal year.

19 (3) APPLICATION OF PROCEEDS.—Amounts re-
20 ceived under paragraph (1) are hereby appropriated
21 to the Secretary to defray the costs described in
22 such paragraph and shall remain available until ex-
23 pended.

24 (c) DEFINITIONS.—In this section:

1 (1) MEDICARE MANAGED CARE CONTRACT.—

2 The term “medicare managed care contract” means
3 a contract under section 1876 or section
4 1833(a)(1)(A) of the Social Security Act.

5 (2) MEDICARE SUPPLEMENTAL POLICY.—The

6 term “medicare supplemental policy” has the mean-
7 ing given such term in section 1882(g) of the Social
8 Security Act.

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