

**Department of Tax and Revenue
Agency Questionnaire**

Re: Legislative Rule to be Filed

MEDICARE SUPPLEMENT INSURANCE

TITLE 114, SERIES 24

Question 1: Are regulations required?

Yes. in December 2000 Congress passed amendments to the Medigap guaranteed issue provisions of section 1882 of the Social Security Act by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). As a result, states are now required to amend their Medicare supplement regulations in order to conform with the new federal standards.

Question 2: Is the rule you are proposing controversial? If yes, what are the pros and the cons?

The amendments to the rule are not expected to be controversial.

Question 3: Is the rule you are proposing a copy of another state's rule? A model rule? Custom-drafted?

The proposed amendments are those adopted by the National Association of Insurance Commissioners ("NAIC") in October of 2001 to the NAIC Medicare Supplement Insurance Minimum Standards Model Act. Series 24 is based upon the model act.

Question 4: What are the really important things you think the Secretary of Tax and Revenue should know about this rule and the issues that surround it?

These rules are needed in order to conform to new federal standards on guaranteed issue periods for Medicare supplement insurance. Following the actions of Congress, the National Association of Insurance Commissioners ("NAIC") adopted amendments to its model Medicare Supplement Regulation in October 2001, and has urged all states to adopt the amendments as soon as possible. The Centers for Medicare & Medicaid Services ("CMS") is currently reviewing all state Medicare supplement insurance (Medigap) regulatory programs to determine compliance with the federal minimum standards, therefore the amendments to 114CSR24 must be undertaken on an emergency basis. The federal amendments to the Social Security Act, upon which the proposed amendments to Series 24 are based, do not expand the class of beneficiaries eligible for guaranteed issue of a Medigap policy, nor do they alter the plans for which eligible beneficiaries are entitled. Rather, the amendments clarify the triggering events for the guaranteed issue period for certain eligible beneficiaries and clarify the beginning and ending dates for the guaranteed issue periods when certain beneficiaries are involuntarily or voluntarily disenrolled under various circumstances.

Insurance Commissioner
Legislative Rule
Title 114, Series 24 - Legislative

MEDICARE SUPPLEMENT INSURANCE

TITLE 114, SERIES 24

BRIEF SUMMARY OF RULE

In December 2000, Congress passed amendments to the Medigap guaranteed issue provisions of section 1882 of the Social Security Act by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). Adoption of these amendments will bring Series 24 into compliance with current federal standards. The federal amendments to the Social Security Act, upon which the proposed amendments to Series 24 are based, do not expand the class of beneficiaries eligible for guaranteed issue of a Medigap policy, nor do they alter the plans for which eligible beneficiaries are entitled. Rather, the amendments clarify the triggering events for the guaranteed issue period for certain eligible beneficiaries and clarify the beginning and ending dates for the guaranteed issue periods when certain beneficiaries are involuntarily or voluntarily disenrolled under various circumstances.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24 - Legislative**

**MEDICARE SUPPLEMENT INSURANCE
TITLE 114, SERIES 24**

STATEMENT OF CIRCUMSTANCES

In December 2000, Congress passed amendments to the Medigap guaranteed issue provisions of section 1882 of the Social Security Act by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). As a result, states are now required to amend their Medicare supplement regulations in order to conform with the new federal standards. Following the actions of Congress, the National Association of Insurance Commissioners ("NAIC") adopted amendments to its model Medicare Supplement Regulation in October 2001, and has urged all states to adopt the amendments as soon as possible. The Centers for Medicare & Medicaid Services ("CMS") is currently reviewing all state Medicare supplement insurance (Medigap) regulatory programs to determine compliance with the federal minimum standards. Adoption of these amendments will bring series 24 into compliance with current federal standards.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Medicare Supplement Insurance
 Title 114, Series 24 - LEGISLATIVE

Type of Rule: Legislative Interpretive Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
 1124 Smith Street, Greenbrooke Building
 Charleston, West Virginia 25305-0540

=====

1. Effect of Proposed Rule

	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None	None	None	None	None
PERSONAL SERVICES	None	None	None	None	None
CURRENT EXPENSE	None	None	None	None	None
REPAIRS AND ALTERATIONS	None	None	None	None	None
EQUIPMENT	None	None	None	None	None
OTHER	None	None	None	None	None

2. Explanation of above estimates:

The amendments to this rule will have no fiscal impact upon the Insurance Commissioner or State Government.

**Rule Title: Medicare Supplement Insurance
Title 114, Series 24 - LEGISLATIVE**

3. Objectives of these rules:

The objective of this rule is to bring the Medicare Supplement Insurance Rule, 114CSR24, into compliance with federal standards. In December 2000, Congress passed amendments to the Medigap guaranteed issue provisions of section 1882 of the Social Security Act by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"). As a result, states are now required to amend their Medicare supplement regulations in order to conform with the new federal standards. Following the actions of Congress, the National Association of Insurance Commissioners ("NAIC") adopted amendments to its model Medicare Supplement Regulation in October 2001, and has urged all states to adopt the amendments as soon as possible. The Centers for Medicare & Medicaid Services ("CMS") is currently reviewing all state Medicare supplement insurance (Medigap) regulatory programs to determine compliance with the federal minimum standards, therefore the amendments to 114CSR24 must be undertaken on an emergency basis. Adoption of these amendments will bring Series 24 into compliance with current federal standards.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

There should be no economic impact as a result of these amendments on political subdivisions, specific industries or specific groups of citizens. The federal amendments to the Social Security Act, upon which the proposed amendments to Series 24 are based, do not expand the class of beneficiaries eligible for guaranteed issue of a Medigap policy, nor do they alter the plans for which eligible beneficiaries are entitled. Rather, the amendments clarify the triggering events for the guaranteed issue period for certain eligible beneficiaries and clarify the beginning and ending dates for the guaranteed issue periods when certain beneficiaries are involuntarily or voluntarily disenrolled under various circumstances.

C. Economic Impact on Citizens/Public at Large.

None

Date: December 17, 2002

Signature of Agency Head or Authorized Representative



Jane L. Cline, Insurance Commissioner

114CSR24

**WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 24
MEDICARE SUPPLEMENT INSURANCE**

Section

- 114-24-1. General.
- 114-24-2. Definitions.
- 114-24-3. Policy Definitions and Terms.
- 114-24-4. Policy Provisions.
- 114-24-5. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to August 5, 1991.
- 114-24-6. Benefit Standards for Policies or Certificates Issued or Delivered on or After August 5, 1991.
- 114-24-7. Standard Medicare Supplement Benefit Plans.
- 114-24-8. Medicare Select Policies and Certificates.
- 114-24-9. Open Enrollment.
- 114-24-10. Guaranteed Issue for Eligible Persons.
- 114-24-11. Standards for Claims Payment.
- 114-24-12. Loss Ratio Standards and Refund or Credit of Premium.
- 114-24-13. Filing and Approval of Policies and Certificates and Premium Rates.
- 114-24-14. Permitted Compensation Arrangements.
- 114-24-15. Required Disclosure Provisions.
- 114-24-16. Requirements for Application Forms and Replacement Coverage.

- 114-24-17. Filing Requirements for Advertising.
 - 114-24-18. Standards for Marketing.
 - 114-24-19. Appropriateness of Recommended Purchase and Excessive Insurance.
 - 114-24-20. Reporting of Multiple Policies.
 - 114-24-21. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.
-
- Appendix A. Medicare Supplement Refund Calculation Form.
 - Appendix B. Outline of Medicare Supplement Coverage--Cover Page.
 - Appendix C. Medicare Supplement Benefit Plans "A" through "J", Respectively (26 pages).
 - Appendix D. Form for Reporting Medicare Supplement Policies.
 - Appendix E. Outline of Medicare Supplement Coverage and Premium Information.
 - Appendix F. Notice to Applicant Regarding Replacement of Medicare Supplement Insurance.
 - Appendix G. Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare.

TITLE 114
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 24
MEDICARE SUPPLEMENT INSURANCE

FILED

2002 DEC 17 P 3 34

OFFICE WEST VIRGINIA
SECRETARY OF STATE

§114-24-1. General.

1.1. Scope. -- The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

1.2. Authority. -- W. Va. Code §§33-28-5b, 33-2-10, and 33-16-3d.

1.3. Filing Date. -- ~~May 30, 2001.~~

1.4. Effective Date. -- ~~May 30, 2001.~~

1.5. Applicability. -- This legislative rule amends West Virginia 114CSR24 "Medicare Supplement Insurance" filed April 24, 2000 and effective on April 24, 2000. Except as otherwise specifically provided, this rule shall apply to:

a. All Medicare supplement policies delivered or issued for delivery in this State or which are otherwise subject to the jurisdiction of this State on or after the effective date hereof, and

b. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

c. This rule shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

§114-24-2. Definitions.

2.1. "Applicant" means:

a. in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

Insurance Commissioner
Legislative Rule
Title 114, Series 24

b. in the case of a group Medicare supplement policy, the proposed certificateholder.

2.2. "Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

2.3. "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

2.4. "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

2.5. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

2.6. "Creditable coverage" means:

a. With respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of Title 5 United States Code

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

(Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

b. "Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

c. "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

d. "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and
2. Hospital indemnity or other fixed indemnity insurance.

e. "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
3. Similar supplemental coverage provided to coverage under a group health plan.

2.7. "Commissioner" means the Insurance Commissioner of the State of West Virginia.

2.8. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

2.9. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

2.10. "Issuer" means insurance company, fraternal benefit society, health care service plan, health maintenance organization, or any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

2.11. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

2.12. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

a. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option),

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

plans offered by provider-sponsored organizations, and preferred provider organization plans;

b. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

c. Medicare+Choice private fee-for-service plans.

2.13. "Medicare Supplement Policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or corporations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) 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.

2.14. "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

2.15. "Secretary" means the Secretary of the United States Department of Health and Human Services.

§114-24-3. Policy Definitions and Terms.

3.1. No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

3.2. "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

b. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

3.3. "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

3.4. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

3.5. "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include:

- a. Home office and overhead costs;
- b. Advertising costs;
- c. Commissions and other acquisition costs;
- d. Taxes;
- e. Capital costs;
- f. Administrative costs; and
- g. Claims processing costs.

3.6. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

3.7. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

3.8. "Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

3.9. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

3.10. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

§114-24-4. Policy Provisions.

4.1. Except for permitted preexisting condition clauses as described in Subdivision a of Subsection 5.2 and Subdivision a of Subsection 6.2 of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

4.2. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

4.3. No Medicare supplement policy or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.

§114-24-5. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to August 5, 1991.

5.1. No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless it meets or exceeds the minimum standards set forth in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

5.2. General Standards. -- The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premium modifications to correspond to such changes are permissible subject to prior approval of the commissioner. Any such proposed premium modifications shall be filed with the commissioner in compliance with procedures applicable to accident and sickness filings generally and with other applicable sections of this rule.

d. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

1. provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

2. be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. Except as authorized by the commissioner, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

1. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph 3 of this Subdivision, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

- A. an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

- B. an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 6.3 of this rule.

2. If membership in a group is terminated, the issuer shall:

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

A. offer the certificateholder such conversion opportunities as are described in Paragraph 1 of this Subdivision; or

B. at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

3. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

5.3. Minimum Benefit Standards.

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount of Medicare eligible expenses under Part

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [\$100];

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

§114-24-6. Benefit Standards for Policies or Certificates Issued or Delivered on or After August 5, 1991.

6.1. The standards set forth in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after August 5, 1991. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards.

6.2. General Standards. -- The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premium modifications to correspond to such changes are permissible subject to prior approval of the commissioner. Any such proposed premium modifications shall be filed with the commissioner in compliance with procedures applicable to accident and sickness filings generally and with other applicable sections of this rule.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

Insurance Commissioner
Legislative Rule
Title 114, Series 24

e. Each Medicare supplement policy shall be guaranteed renewable.

1. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

2. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

3. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Paragraph 5 of this Subdivision, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

A. Provides for continuation of the benefits contained in the group policy, or

B. Provides for such benefits as otherwise meet the requirements of this subsection.

4. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

A. Offer the certificateholder the conversion opportunity described in Paragraph 3 of this Subdivision, or

B. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

5. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

g. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

1. If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

2. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

3. Reinstitution of such coverages:

A. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

B. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

C. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

6.3. Standards for Basic Core Benefits Common to All Benefit Plans. -- Every issuer shall make available a policy or certificate including only the following basic core package of

Insurance Commissioner
Legislative Rule
Title 114, Series 24

benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu thereof.

- a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
- c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;
- d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
- e. Coverage for the coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6.4. Standards for Additional Benefits. -- The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 7 of this rule.

- a. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
- b. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.
- c. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- d. Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

g. Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

h. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive Medical Care Benefit: Coverage for the following preventive health services:

1. An annual clinical preventive medical history and physical examination that may include tests and services from Paragraph 2 of this Subdivision and patient education to address preventive health care measures.

2. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

A. Digital rectal examination;

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

- B. Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
- C. Pure tone (air only) hearing screening test, administered or ordered by a physician;
- D. Serum cholesterol screening (every five (5) years);
- E. Thyroid function test;
- F. Diabetes screening.

3. Tetanus and Diphtheria booster (every ten (10) years).

4. Any other tests or preventive measures determined appropriate by the attending physician.

A. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

1. For purposes of this benefit, the following definitions shall apply:

A. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

B. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a 24-hour period of services provided by a care provider is one visit.

C. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

agency or referred by a licensed referral agency or licensed nurses' registry.

D. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

2. Coverage Requirements and Limitations

A. At-home recovery services provided must be primarily services which assist in activities of daily living.

B. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

C. Coverage is limited to:

1. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

2. The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

3. One thousand six hundred dollars (\$1,600) per calendar year;

4. Seven (7) visits in any one week;

5. Care furnished on a visiting basis in the insured's home;

6. Services provided by a care provider as defined in this section;

7. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

8. At-home recovery visits received during the period the

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

3. Coverage is excluded for:

A. Home care visits paid for by Medicare or other government programs; and

B. Care provided by family members, unpaid volunteers or providers who are not care providers.

k. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

§114-24-7. Standard Medicare Supplement Benefit Plans.

7.1. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 6.3 of this rule.

7.2. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this State, except as may be permitted in Subdivision k of Subsection 6.4 and in Section 8, [*Section 8 of this rule will not take effect until West Virginia is designated a Medicare Select State by the federal government], of this rule.

7.3. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in Section 2 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 6.3 and 6.4 and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

7.4. An issuer may use, in addition to the benefit plan designations required in Subsection 7.3, other designations to the extent permitted by law.

7.5. Make-up of benefit plans:

Insurance Commissioner
Legislative Rule
Title 114, Series 24

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic Core Benefits Common to All Benefit Plans, as defined in Subsection 6.3 of this rule.

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible as defined in Subdivision a of Subsection 6.4.

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Subdivisions a, b, c and h of Subsection 6.4 respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Subdivisions a, b, h and j of Subsection 6.4 respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Subdivisions a, b, h and i of Subsection 6.4 respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Subdivisions a, b, c, e and h of Subsection 6.4 respectively.

g. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subdivisions a, b, c, e, and h of Subsection 6.4. respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare

Insurance Commissioner
Legislative Rule
Title 114, Series 24

supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

h. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Subdivisions a, b, d, h and j of Subsection 6.4 respectively.

i. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Outpatient Prescription Drug Benefit, and Medically Necessary Emergency Care in a Foreign Country as defined in Subdivisions a, b, f and h of Subsection 6.4 respectively.

j. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Subdivisions a, b, e, f, h and j of Subsection 6.4 respectively.

k. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Subdivisions a, b, c, e, g, h, i and j of Subsection 6.4 respectively

l. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Subsection 6.3 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

Subdivisions a, b, c, e, g, h, i and j of Subsection 6.4. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

§114-24-8. Medicare Select Policies and Certificates.

[*Section 8 of this rule will not take effect until West Virginia is designated a Medicare Select State by the federal government.]

8.1. This section shall apply to Medicare Select policies and certificates, as defined in this section.

8.2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

8.3. For the purposes of this section:

a. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

b. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

c. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

d. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

e. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

f. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

g. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

8.4. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this rule.

8.5. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the commissioner.

8.6. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

1. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

2. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

A. To deliver adequately all services that are subject to a restricted network provision; or

B. To make appropriate referrals.

3. There are written agreements with network providers describing specific responsibilities.

4. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

5. In the case of covered services that are subject to a restricted network

Insurance Commissioner
Legislative Rule
Title 114, Series 24

provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

- b. A statement or map providing a clear description of the service area.
- c. A description of the grievance procedure to be utilized.
- d. A description of the quality assurance program, including:
 - 1. The formal organizational structure;
 - 2. The written criteria for selection, retention and removal of network providers; and
 - 3. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
- e. A list and description, by specialty, of the network providers.
- f. Copies of the written information proposed to be used by the issuer to comply with Subsection 8.10.
- g. Any other information requested by the commissioner.

8.7. A Medicare Select issuer shall file:

- a. Any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.
- b. An updated list of network providers with the commissioner at least quarterly.

8.8. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

- a. The services are for symptoms requiring emergency care or are immediately

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

required for an unforeseen illness, injury or a condition; and

b. It is not reasonable to obtain such services through a network provider.

8.9. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

8.10. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

1. Other Medicare supplement policies or certificates offered by the issuer; and

2. Other Medicare Select policies or certificates.

b. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

d. A description of coverage for emergency and urgently needed care and other out of service area coverage.

e. A description of limitations on referrals to restricted network providers and to other providers.

f. A description of the policyholder's right to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

g. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

8.11. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

information provided pursuant to Subsection 8.10 of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

8.12. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

b. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

c. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action shall be taken promptly.

e. All concerned parties shall be notified about the results of a grievance.

f. The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

8.13. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

8.14. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

a. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

the purposes of this Subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for outpatient prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

8.15. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

a. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for outpatient prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

8.16. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

§114-24-9. Open Enrollment.

9.1. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

9.2. If an applicant qualifies under Subsection 9.1 of this section and submits an

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

application during the time period referenced in Subsection 9.1, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

9.3. If the applicant qualifies under Subsection 9.1 of this section and submits an application during the time period referenced in Subsection 9.1 and, as of the date of application has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of an preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

9.4. Except as provided in Subsections 9.2 and 9.3 of this section and Section 21, Subsection 9.1 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

§114-24-10. Guaranteed Issue for Eligible Persons.

10.1. Eligible persons are those individuals described in Subsection 10.2 of this section who, ~~subject to Paragraph 2 of Subdivision b of Subsection 10.2, apply~~ seek to enroll under the policy during the period specified not later than sixty three (63) days after the date of the termination of enrollment described in Subsection 10.2 10.3 of this section, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

a. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in ~~Subsection 10.3~~ 10.5 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

10.2. An eligible person is an individual described in any of the following Subdivisions:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

b. ~~4.~~ The individual is enrolled with a Medicare+Choice organization under

Insurance Commissioner
Legislative Rule
Title 114, Series 24

a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

~~A. 1. The certification of the organization or plan under this series has been terminated, or the organization or plan has notified the individual of an impending termination of such certification;~~

~~B. 2. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;~~

~~C. 3. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;~~

~~D. 4. The individual demonstrates, in accordance with guidelines established by the Secretary, that:~~

~~1. A. The organization offering the plan substantially violated a material provision of the organization's contract under this series in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or~~

~~2. B. The organization or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or~~

~~E. 5. The individual meets such other exceptional conditions as the Secretary may provide.~~

~~2. — A. An individual described in Paragraph 1 of this Subdivision may elect to apply Subsection 10.1 by substituting, for the date of termination of enrollment, the date~~

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

~~on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.~~

~~B. In the case of an individual making the election in Subparagraph A of this Paragraph, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under Subsection 10.1 shall only become effective upon termination of coverage under the Medicare+Choice plan involved.~~

c. 1. The individual is enrolled with:

A. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost);

B. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

C. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

D. An organization under a Medicare Select policy; and

2. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Subdivision b of Subsection 10.2 of this section.

d. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

1. Of the insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy;

2. The issuer of the policy substantially violated a material provision of the policy; or

3. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

Insurance Commissioner
Legislative Rule
Title 114, Series 24

e. 1. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost) any similar organization operating under demonstration project authority, any PACE program provider under Section 1894 of the Social Security Act, ~~an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan)~~, or a Medicare Select policy; and

2. The subsequent enrollment under Paragraph 1 of this Subdivision is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

f. The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, or ~~in~~ with a PACE program provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

10.3. Guaranteed Issue Time Periods

a. In the case of an individual described in Subdivision a of Subsection 10.2, the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends sixty-three (63) days after the date of the applicable notice;

b. In the case of an individual described in Subdivisions b, c, e or f of Subsection 10.2 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

c. In the case of an individual described in Paragraph 1, Subdivision d of Subsection 10.2, the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

d. In the case of an individual described in Subdivision b, Paragraph 2 of Subdivision d, Paragraph 3 of Subdivision d, Subdivision e or Subdivision f of Subsection 10.2 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and

e. In the case of an individual described in Subsection 10.2 but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date

10.4. Extended Medigap Access for Interrupted Trial Periods

a. In the case of an individual described in Subdivision e of Subsection 10.2 (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Paragraph 1, Subdivision e of Subsection 10.2 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Subdivision e of Subsection 10.2;

b. In the case of an individual described in Subdivision f of Subsection 10.2 (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subdivision f of Subsection 10.2 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Subdivision f of Subsection 10.2; and

c. For purposes of Subdivisions e and f of Subsection 10.2, no enrollment of an individual with an organization or provider described in Paragraph 1, Subdivision e of Subsection 10.2, or with a plan or in a program described in Subdivision f of Subsection 10.2, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

~~10.3.~~ 10.5. The Medicare supplement policy to which eligible persons are entitled under:

a. Subdivisions a, b, c, and d of Subsection 10.2 of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any insurer.

b. Subdivision e of Subsection 10.2 of this section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subdivision a of this Subsection.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

c. Subdivision f of Subsection 10.2 of this section shall include any Medicare supplement policy offer by any issuer.

~~10.4.~~ 10.6. Notification provisions are as follows:

a. At the time of an event described in Subsection 10.2 of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 10.1. Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in Subsection 10.2 of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 10.1 of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

§114-24-11. Standards for Claims Payment.

11.1. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating physician or supplier and the beneficiary of the payment determination;

c. Paying the participating physician or supplier directly;

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

may be sent;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

11.2. Compliance with the requirements set forth in Subsection 10.1 above shall be certified on the Medicare supplement insurance experience reporting form.

§114-24-12. Loss Ratio Standards and Refund or Credit of Premium.

12.1. Loss Ratio Standards.

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless:

1. The policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

A. At least ~~75 percent~~ seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or

B. At least ~~65 percent~~ sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

2. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

b. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

c. For purposes of applying Subdivision a of Subsection 12.1 and Subdivision b of Subsection 13.3 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

d. For policies issued prior to April 28, 1996, expected claims in relation to premiums shall meet:

1. The originally filed anticipated loss ratio when combined with the actual experience since inception;

2. The appropriate loss ratio requirement from Subparagraphs A and B of Paragraph 1 of Subdivision a of Subsection 12.1 when combined with actual experience beginning April 28, 1996; and

3. The appropriate loss ratio requirement from Subparagraphs A and B of Paragraph 1 of Subdivision a of Subsection 12.1 over the entire future period for which the rates are computed to provide coverage.

12.2. Refund or Credit Calculation.

a. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan. Appendix A, which is hereby incorporated into this rule by reference, is annexed hereto and entitled "Reporting Form for Calculation of Loss Ratios."

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

c. For the purposes of this section, policies or certificates issued prior to April 28, 1996, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.

d. A refund or credit shall be made only when the benchmark loss ratio exceeds

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

12.3. Annual Filing of Premium Rates.

a. An issuer of Medicare supplement policies and certificates issued before or after the effective date of these "Permanent Regulations on Medicare Supplement Insurance" in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

b. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this State shall file with the commissioner, in accordance with the applicable filing procedures of this State:

1. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

A. An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement insurance policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

B. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

credits deemed necessary to achieve the loss ratio required by this section.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

12.4. Public Hearings.

a. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner consistent with the provisions of W. Va. Code §§33-2-12 and 33-2-13. Nothing in this subsection shall be construed so as to limit the authority of the commissioner to conduct hearings regarding rates, to the extent that the laws of this State grant such authority.

§114-24-13. Filing and Approval of Policies and Certificates and Premium Rates.

13.1. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

13.2. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

13.3. Except as provided in Subdivision a of this Subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

a. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

1. The inclusion of new or innovative benefits;

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

2. The addition of either direct response or agent marketing methods;

3. The addition of either guaranteed issue or underwritten coverage;

4. The offering of coverage to individuals eligible for Medicare by reason of disability.

b. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy,* or a group Medicare Select policy. [*These provisions regarding Medicare Select policies will not take effect until West Virginia is designated a Medicare Select State by the federal government.]

13.4. Except as provided in Paragraph 1 of Subdivision a of this Subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner.

a. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this State.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 1 of Subdivision a of this Subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

c. A change in the rating structure or methodology shall be considered a discontinuance under Subsection 13.4 unless the issuer complies with the following requirements:

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

13.5. Refund or Credit Calculation.

a. Except as provided in Subdivision b of this Subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 12.

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

§114-24-14. Permitted Compensation Arrangements.

14.1. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no greater than the commission or other compensation paid for selling or servicing the policy or certificate during each of the next four years or periods of the policy.

14.2. Beginning with the sixth year or period of the policy or certificate and for each year or period thereafter, the agent or producer shall receive no commission or compensation other than a maximum ten percent (10%) maintenance or service fee per policy year or period.

14.3. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

14.4. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finder's fees.

§114-24-15. Required Disclosure Provisions.

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

15.1. General Rules.

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy, be labeled as "Preexisting Condition Limitations," and be placed on the first page of the policy.

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare*

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. For purposes of this section, "form" means the language, format, type size, promotional spacing, bold character, and line spacing. Delivery of the *Guide* shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

15.2. Notice Requirements.

a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice shall:

1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

2. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

c. The notices shall not contain or be accompanied by any solicitation.

15.3. Outline of Coverage Requirements for Medicare Supplement Policies.

a. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All Medicare Supplement Benefit Plans "A" through "J" shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

d. The following items shall be included in the outline of coverage in the order prescribed in Appendix E at the end of this rule. Appendix B, entitled "Outline of Medicare Supplement Coverage--Cover Page," which is incorporated into this rule by reference and annexed hereto, prescribes the information to be contained on the cover page. The required premium information and disclosure pages are in Appendix E of this rule. Examples of charts displaying the features of each Medicare supplement benefit plan offered by the issuer is contained in Appendix C, which is annexed hereto and incorporated herein by reference.

15.4. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

a. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. §1395 et seq.); disability income policy; or other policy identified in Subdivision c of Subsection 1.5 of this rule, issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

b. Applications provided to persons eligible for Medicare for the health insurance

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

policies or certificates described in Subdivision a of this Subsection shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

§114-24-16. Requirements for Application Forms and Replacement Coverage.

16.1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other accident and sickness insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

a. Statements:

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. The benefits and premiums under your Medicare supplement policy can be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

b. Questions:

1. To the best of your knowledge:
 - A. Do you have another Medicare supplement policy or certificate

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

in force?

1. If so, with which company?

2. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

B. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

1. If so, with which company?

2. What kind of policy?

C. Are you covered for medical assistance through the State Medicaid program:

(SLMB)?

1. As a Specified Low Income Medicare Beneficiary

2. As a Qualified Medicare Beneficiary (QMB)?

3. For other Medicaid medical benefits?

16.2. Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five (5) years which are no longer in force.

16.3. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

16.4. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

issuer shall deliver to the applicant, at the time of the issuance of the policy, the notice regarding replacement of Medicare supplement coverage.

16.5. The notice required by Subsection 16.4 for an issuer shall be provided in substantially the form at the end of this rule (Appendix F) in no less than twelve (12) point type.

16.6. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

§114-24-17. Filing Requirements for Advertising.

17.1. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the commissioner for review. Such advertisement shall comply with all laws of this State, including, when applicable, the provisions of W. Va. Code §§33-6-8(e), 33-6-35, and 33-11-4(2).

§114-24-18. Standards for Marketing.

18.1. An issuer, directly or through its producers, shall:

a. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

b. Establish marketing procedures to assure excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

e. Establish auditable procedures for verifying compliance with this Subsection.

18.2. In addition to the practices prohibited in this State's Unfair Trade Practices Act [W. Va. Code §33-11-1 et seq.], the following acts and practices are prohibited:

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

a. Twisting. -- Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. High pressure tactics. -- Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. Cold lead advertising. -- Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

18.3. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

§114-24-19. Appropriateness of Recommended Purchase and Excessive Insurance.

19.1. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

19.2. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

§114-24-20. Reporting of Multiple Policies.

20.1. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this State for whom the issuer has in force more than one Medicare supplement policy or certificate:

a. Policy and certificate number, and

b. Date of issuance.

20.2. The items set forth above must be grouped by individual policyholder.

20.3. To comply with this section, an issuer shall use the form incorporated herein by

**Insurance Commissioner
Legislative Rule
Title 114, Series 24**

reference and annexed hereto as Appendix D, entitled "Form for Reporting Duplicate Policies."

§114-24-21. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

21.1. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

21.2. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Appendix A

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE ¹ _____	SMSBP ² _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

<u>Line</u>	(a) Earned Premium ³	(b) Incurred Claims ⁴
1. Current Year's Experience		
a. Total (all policy years)	_____	_____
b. Current year's issues ⁵	_____	_____
c. Net (for reporting purposes=1a-1b)	_____	_____
2. Past Years' Experience (all policy years)	_____	_____
3. Total Experience (Net Current Year + Past Year)	_____	_____
4. Refunds Last Year (Excluding Interest)	_____	_____
5. Previous Since Inception (Excluding Interest)	_____	_____
6. Refunds Since Inception (Excluding Interest)	_____	_____
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)	_____	_____
8. Experienced Ratio Since Inception Total Actual Incurred Claims (line 3, col. b) = Ratio 2/ Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)		_____
9. Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		_____
10. Tolerance Permitted (obtained from Credibility Table)		_____

Medicare Supplement Credibility Table

Life Years Exposed	
<u>Since Inception</u>	<u>Tolerance</u>
10,000+	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

¹ Individual Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Includes Modal Loadings and Fees Charged

⁴ Excludes Active Life Reserves

⁵ This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE¹ _____
For the State of _____
NAIC Group Code _____
Address _____
Title _____

SMSBP² _____
Company Name _____
NAIC Company Code _____
Person Completing Exhibit _____
Telephone Number _____

11. Adjustment to Incurred Claims for Credibility
Ratio 3 = Ratio 2 + Tolerance _____

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims
[Total Earned Premiums (line 3, col. a) - Refunds since Inception (line 6)] X Ratio 3 (line 11) _____

13. Refund =
Total Earned Premiums (line 3, col. a) - Refunds Since Inception
(line 6) - Adjusted Incurred Claims (line 12)/
Benchmark Ratio (Ratio 1) _____

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name - Please Type

Title - Please Type

Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR _____

TYPE: _____
 For the State of _____
 NAIC Group Code _____
 Address _____
 Title _____

SMSBP² _____
 Company Name _____
 NAIC Company Code _____
 Person Completing Exhibit _____
 Telephone Number _____

(a) ¹ Year	(b) ⁴ Earned Premium	(c) Factor	(d) (b)(c)	(e) Cumulative Loss Ratio	(f) (d)(e)	(g) Factor	(h) (b)(g)	(i) Cumulative Loss Ratio	(j) (h)(j)	(k) ⁵ Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l+n)/(k+m)$: _____

- 1 Individual Group, Individual Medicare Select, or Group Medicare Select Only.
- 2 *SMSBP* = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
- 3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- 4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- 5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ¹	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
Year	Earned Premium	Factor	(b)(c)	Cumulative Loss Ratio	(d)(e)	Factor	(b)(g)	Cumulative Loss Ratio	(h)(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k)		(l)		(m)		(n)	

Benchmark Ratio Since Inception: $(1+n)/(k+m)$: _____

1 Individual Group, Individual Medicare Select, or Group Medicare Select Only.

2 SMSBP² - Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE -- COVER PAGE

Benefit Plan(s) __ [Insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
	Part A Deductible	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (80%)	Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
		At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery
								Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)
				Preventive Care							Preventive Care

*Plans F and J also have an option called a high deductible Plan F and high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plan F and J after one has paid a calendar year [\$1530] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$[1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

APPENDIX C

PLAN A
 MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the Additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$0 \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$[776] (Part A Deductible) \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 \$0 \$0	\$0 Up to \$[97] a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN A
MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amount(s))	\$0	\$0	All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
---	------------------------	-----------------------	---

PLAN B
MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 \$0 \$0	\$0 Up to \$[97] a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN B

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
---	--------------------	-------------------	---

PLAN C

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN C

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$0	\$0 \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
---	--------------------	---	-------------------

OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
---	------------	--	--

PLAN D

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN D

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
--	--------------------	-------------------	---

PLAN D

MEDICARE (PARTS A & B) - (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES -- NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan</p> <ul style="list-style-type: none"> - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar Year Maximum 	<p>\$0 \$0 \$0</p>	<p>Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600</p>	<p>Balance</p>

OTHER BENEFITS -- NOT COVERED BY MEDICARE

<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
---	---	---	--

PLAN E

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN B

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
--	--------------------	-------------------	---

PLAN E

OTHER BENEFITS -- NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <p>First \$250 each Calendar Year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
<p>*PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</p> <p>Some Annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare</p> <p>First \$120 each Calendar Year Additional charges</p>	<p>\$0 \$0</p>	<p>\$120 \$0</p>	<p>\$0 All Costs</p>

* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1530] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1530] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0*** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD -- (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1530] DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$0	Balance

PLAN F FOR HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.
 **This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1530] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1530] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible Generally 20% \$100	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
--	--------------------	---	-------------------

PLAN F OR HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR -- (continued)

OTHER BENEFITS -- NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1530] DEDUCTIBLE,** YOU PAY
<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

PLAN G

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN G

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 80%	\$100 (Part B Deductible) \$0 20%
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
--	--------------------	-------------------	---

PLAN G

MEDICARE (PARTS A & B) -- (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks Of last Medicare Approved visit) - Calendar Year Maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
---	------------	--	---

PLAN H

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN H

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts			

PLAN H

MEDICARE (PARTS A & B) -- (continued)

OTHER BENEFITS -- NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each Calendar Year Next \$2,500 each Calendar Year Over \$2,500 each Calendar Year	\$0 \$0 \$0	\$0 50% - \$1,250 calendar year maximum benefit \$0	\$250 50% All Costs

PLAN I

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN I

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	\$100 (Part B Deductible) \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
--	--------------------	-------------------	---

PLAN I

MEDICARE (PARTS A & B) -- (continued)

SERVICES	MEDICARE PAY	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar Year Maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each Calendar Year Next \$2,500 each Calendar Year Over \$2,500 each Calendar Year	\$0 \$0 \$0	\$0 50% - \$1,250 calendar year maximum benefit \$0	\$250 50% All Costs

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
 **This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1530] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.
 NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1530] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A Deductible) \$[194] a day \$[388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0*** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[97] a day \$0	\$0 Up to \$[97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

PLAN J of HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD, (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1530] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO [\$1530] DEDUCTIBLE, ** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1530] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1530] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
--	--------------------	---	-------------------

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1530] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar Year Maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each Calendar Year Next \$6,000 each Calendar Year Over \$6,000 each Calendar Year	\$0 \$0 \$0	\$0 50% - \$3,000 calendar year maximum benefit \$0	\$250 50% All Costs
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE *** Annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each Calendar Year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (Please Type)

Date

APPENDIX E

[COMPANY NAME]
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE
AND PREMIUM INFORMATION

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct responses:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are incorporated into this regulation by reference and annexed hereto collectively as Appendix C, "Medicare Supplement Benefits Plans 'A' through 'J', Respectively." An issuer may use additional benefit plan designations on these charts pursuant to Subsection 7.4 of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

[DRAFTING NOTE: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.]

APPENDIX F

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Other. (please specify) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or
Other Representative*

[Typed Name and Address of
Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

DISCLOSURE STATEMENTS

**Instructions for Use of the Disclosure Statements for
Health Insurance Policies Sold to Medicare Beneficiaries
that Duplicate Medicare**

1. Section 1882(d) of the federal Social Security Act [42U.S.C. 1395ss], prohibits the sale of a health insurance policy (the term policy or policies includes certificates) to Medicare beneficiaries that duplicate Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix G remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for both expenses incurred and fixed indemnity basis]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the previous statements]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited reimbursement for expenses if you meet the policy conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.

These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

H. R. 5661

FULL TEXT OF BILLS

106th CONGRESS, 2ND SESSION
IN THE HOUSE OF REPRESENTATIVES
AS INTRODUCED IN THE HOUSE

H. R. 5661

2000 H.R. 5661; 106 H.R. 5661

SYNOPSIS:

A bill to amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

DATE OF INTRODUCTION: December 14, 2000

SPONSOR(S):

Sponsor and Cosponsors as of 12/20/2000
THOMAS, WILLIAM M (R-CA) - Sponsor

TEXT:

HR 5661 IH

106th CONGRESS

2d Session

H. R. 5661

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

December 14, 2000

Mr. Thomas (for himself, Mr. Bliley, and Mr. Bilirakis) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, 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

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO OTHER ACTS; TABLE OF CONTENTS.

(a) Short Title. This Act may be cited as the "Medicare, Medicaid, and **SCHIP Benefits Improvement and Protection Act of 2000**".

SEC. 618. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.

(a) Disenrollment Window in Accordance With Beneficiary's Circumstance. Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended--

(1) in subparagraph (A), in the matter following clause (iii), by striking ", subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph" and inserting "seeks to enroll under the policy during the period specified in subparagraph (E)"; and

(2) by striking subparagraph (E) and inserting the following new subparagraph:

"(E) For purposes of subparagraph (A), the time period specified in this subparagraph is--

"(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

"(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated

involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

"(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

"(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

"(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date."

(b) Extended Medigap Access for Interrupted Trial Periods. Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)), as amended by subsection (a), is further amended by adding at the end the following new subparagraph:

"(F)(i) Subject to clause (ii), for purposes of this paragraph--

"(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

"(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent

enrollment shall be deemed to be an initial enrollment described in such clause.

"(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v)(II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year

period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program."

LEXSTAT 42 USC 1395SS

UNITED STATES CODE SERVICE
Copyright © 2002 Matthew Bender & Company, Inc.,
one of the LEXIS Publishing (TM) companies
All rights reserved

*** CURRENT THROUGH P.L. 272, APPROVED 10/30/02 ***

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 7. SOCIAL SECURITY ACT

TITLE XVIII. HEALTH INSURANCE FOR THE AGED AND DISABLED

PART D. MISCELLANEOUS PROVISIONS

GO TO CODE ARCHIVE DIRECTORY FOR THIS JURISDICTION

42 USCS § 1395ss (2002)

§ 1395ss. Certification of Medicare supplemental health insurance policies

(a) Submission of policy by insurer.

(1) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Subject to subsections (k)(3), (m), and (n), such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(c) unless--

(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the 1991 NAIC Model Regulation or 1991 Federal Regulation (as the case may be)) by the date specified in subsection (p)(1)(c); or

(B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, on and after the effective date specified in subsection (p)(1)(C), in violation of this paragraph is subject to a civil money penalty of not to exceed \$ 25,000 for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(b) Standards and requirements; periodic review by Secretary.

(1) [Caution: For application and termination of Nov. 5, 1990 amendment of this section, see § 4358(c) of Act Nov. 5, 1990, P.L. 101-508, which appears as a note to this section.] Any medicare supplemental policy issued in any State which the Secretary determines has established under State law a regulatory program that--

(A) [Caution: For application and termination of 1990 amendment, see § 4358(c) of Act Nov. 4, 1990, P.L. 101-508, which appears as a note to this section.] provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A)), except as otherwise provided by subparagraph (H);

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c);

(C) provides that--

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

(H) [Caution: For application and termination of this subparagraph, see § 4358(c) of Act Nov. 4, 1990, P.L. 101-508, which appears as a note to this section.] in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t),

shall be deemed (subject to subsections (k)(3), (m), and (n), for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). Each report required under subparagraph (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards and requirements of this paragraph, actions taken by the State to bring such policies into compliance, information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners may specify.

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such

standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.

(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.

(c) Requisite findings. The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3) or the requirement described in subsection (s), the issuer of the policy)--

(1) [Caution: For application and termination of Nov. 5, 1990 amendment of this section, see § 4358(c) of Act Nov. 5, 1990, P.L. 101-508, which appears as a note to this section.] meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t));

(2) meets the requirements of subsection (r);

(3) (A) accepts a notice under section 1842(h)(3)(B) [42 USCS § 1395u(h)(3)(B)] as a claim form for benefits under such policy in lieu of any claim form otherwise required and agrees to make a payment determination on the basis of the information contained in such notice;

(B) where such a notice is received--

(i) provides notice to such physician or supplier and the beneficiary of the payment determination under the policy, and

(ii) provides any payment covered by such policy directly to the participating physician or supplier involved;

(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1842(h)(3)(B) [42 USCS § 1395u(h)(3)(B)] respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1842(h)(3)(B) [42 USCS § 1395u(h)(3)(B)] with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1842(h)(3)(B) [42 USCS § 1395u(h)(3)(B)] respecting the policy are to be sent;

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and

(5) meets the applicable requirements of subsections (o) through (t).

(d) Criminal penalties; civil penalties for certain violations.

(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 5,000 for each such prohibited act.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title [42 USCS § § 1395 et seq.], or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined under title 18, United States

Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 5,000 for each such prohibited act.

(3) (A) (i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A [42 USCS § § 1395c et seq.] or enrolled under part B of this title [42 USCS § § 1395j et seq.] (including an individual electing a Medicare + Choice plan under section 1851)--

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX [42 USCS § § 1395 et seq. or 1396 et seq.],

(II) in the case of an individual not electing a Medicare + Choice plan[,] a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy or in the case of an individual electing a Medicare + Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare + Choice plan or under another medicare supplemental policy, or

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(ii) Whoever violates clause (i) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 25,000 (or \$ 15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate clause (i)(II) with respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subparagraph, a health insurance policy (other than a Medicare supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" any health benefits under this title [42 USCS § § 1395 et seq.], under title XIX [42 USCS § § 1396 et seq.], or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.

(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to "duplicate" health benefits under this title or under another health insurance policy if it--

(I) provides health care benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof,

(II) coordinates against or excludes items and services available or paid for under this title or under another health insurance policy, and

(III) for policies sold or issued on or after the end of the 90-day period beginning on the date of enactment of the Health Insurance Portability and Accountability Act of 1996 [enacted Aug. 21, 1996] discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms "coordinates" and "coordination" mean, with respect to a policy in relation to health benefits under this title or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title [42 USCS § § 1395 et seq.] or under another health insurance policy.

(vi) (I) An individual entitled to benefits under part A [42 USCS § § 1395c et seq.] or enrolled under part B of this title [42 USCS § § 1395j et seq.] who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be furnished as a part of (or together with) the application for such policy.

(II) Whoever issues or sells a health insurance policy (other than a policy described in subclause (III)) to an individual described in subclause (I) and fails to furnish the appropriate disclosure statement as required under such subclause shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 25,000 (or \$ 15,000 in the case of a person other than the issuer of the policy) for each such violation.

(III) A policy described in this subclause (to which subclauses (I) and (II) do not apply) is a Medicare supplemental policy, a policy described in clause (v), or a health insurance policy identified under *60 Federal Register 30880* (June 12, 1995) as a policy not required to have a disclosure statement.

(IV) Any reference in this section to the revised NAIC model regulation (referred to in subsection (m)(1)(A)) is deemed a reference to such regulation as revised by section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103-432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before the date of the enactment of the Health Insurance Portability and Accountability Act of 1996 [enacted Aug. 21, 1996]) for that type of policy, as revised as follows:

(I) In each statement, amend the second line to read as follows:

"THIS IS NOT MEDICARE SUPPLEMENT INSURANCE".

(II) In each statement, strike the third line and insert the following: "Some health care services paid for by Medicare may also trigger the payment of benefits under this policy."

(III) In each statement not described in subclause (V), strike the boldface matter that begins "This insurance" and all that follows up to the next paragraph that begins "Medicare".

(IV) In each statement not described in subclause (V), insert before the boxed matter (that states "Before You Buy This Insurance") the following: "This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance."

(V) In a statement relating to policies providing both nursing home and non-institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins "Federal law" to read as follows: "Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare."

(viii) (I) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State's ability to regulate health insurance policies, including any health insurance policy that is described in clause (iv), (v), or (vi)(III).

(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A [42 USCS § § 1395c et seq.] or enrolled under part B [42 USCS § § 1395j et seq.] "duplicates" health benefits under this title [42 USCS § § 1395 et seq.] or under a Medicare supplemental policy.

(B) (i) It is unlawful for a person to issue or sell a Medicare supplemental policy to an individual entitled to benefits under part A [42 USCS § § 1395c et seq.] or enrolled under part B [42 USCS § § 1395j et seq.], whether directly, through the mail, or otherwise, unless--

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause ii, a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies (including any Medicare + Choice plan) the individual has, from what source, and whether the individual is

entitled to any medical assistance under title XIX [42 USCS § § 1396 et seq.], whether as a qualified medicare beneficiary or otherwise, and

(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that-

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

(II) states in substance that individuals may be eligible for benefits under the State medicaid program under title XIX [42 USCS § § 1396 et seq.] and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such title [42 USCS § § 1396 et seq.] and may be reinstated upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii) (I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has a medicare supplemental policy or indicates that the individual is entitled to any medical assistance under title XIX [42 USCS § § 1396 et seq.], the sale of a medicare supplemental policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has a medicare supplemental policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer [issuer's] or seller's knowledge, duplicate coverage (taking into account any such replacement).

(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX [42 USCS § § 1396 et seq.], the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such title pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1905(p)(1) [42 USCS § 1396d(p)(1)], the policy provides for coverage of outpatient prescription drugs, or (cc) the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)].

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 25,000 (or \$ 15,000 in the case of a seller who is not the issuer of a policy) for each such violation.

(C) Subparagraph (A) shall not apply with respect to the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4) (A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed.

(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).

(5) The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a) [42 USCS § 1320a-7a(a)].

(e) Dissemination of information.

(1) The Secretary shall provide to all individuals entitled to benefits under this title [42 USCS § § 1395 et seq.] (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title [42 USCS § § 1395 et seq.].

(2) The Secretary shall--

(A) inform all individuals entitled to benefits under this title [42 USCS § § 1395 et seq.] (and, to the extent feasible, individuals about to become so entitled) of--

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this title [42 USCS § § 1395 et seq.] and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f) Study and evaluation of comparative effectiveness of various State approaches to regulating medicare supplemental policies; report to Congress no later than January 1, 1982; periodic evaluations.

(1) (A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title [42 USCS § § 1395 et seq.] (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this title [42 USCS § § 1395 et seq.].

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such

recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of--

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this title [42 USCS § § 1395 et seq.] of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX [42 USCS § § 1396 et seq.] to such policies).

(g) Definitions.

(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title [42 USCS § § 1395 et seq.], which provides reimbursement for expenses incurred for services and items for which payment may be made under this title [42 USCS § § 1395 et seq.] but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title [42 USCS § § 1395 et seq.]; but does not include a Medicare + Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b) [42 USCS § 1395mm(b)]) if the policy or plan provides benefits pursuant to a contract under section 1876 [42 USCS § 1395mm] or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983 [unclassified], section 2355 of the Deficit Reduction Act of 1984 [unclassified], or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 [unclassified], or a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A) [42 USCS § 1395l(a)(1)(A)]. For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term "NAIC Model Standards" means the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement [supplemental] policies.

(B) The term "State with an approved regulatory program" means a State for which the Secretary has made a determination under subsection (b)(1).

(C) The State in which a policy is issued means--

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) Rules and regulations. The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

(i) Commencement of certification program.

(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2) (A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Interstate and Foreign Commerce [Committee on Energy and Commerce] and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) State regulation of policies issued in other States. Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

(k) Amended NAIC Model Regulation or Federal model standards applicable; effective date; medicare supplemental policy and State regulatory program meeting applicable standards.

(1) (A) If, within the 90-day period beginning on the date of the enactment of this subsection [enacted July 1, 1988] the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, except as provided in subsection (m), subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the "amended NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2) (A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as "Federal model standards") for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal

model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsections (l), (m), and (n))--

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(1) Transitional compliance with NAIC Model Transition Regulation; "qualifying medicare supplement policy" and "NAIC Model Transition Regulation" defined; report to Congress respecting State action in adopting equal or more stringent standards.

(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued--

(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy--

(A) issued in a State which--

(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3) (A) The date specified in this paragraph is the earlier of--

(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identifies as--

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph 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 January 1, 1989, and in which legislation described in clause (i) may be considered. 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.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date--

(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation), the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title [42 USCS § § 1395 et seq.] and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains--

(A) the improved benefits under this title [42 USCS § § 1395 et seq.] contained in the Medicare Catastrophic Coverage Act of 1988, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term "NAIC Model Transition Regulation" refers to the standards contained in the "Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions" (as adopted by the National Association of Insurance Commissioners in September 1987).

(m) Revision of amended NAIC Model Regulation and amended Federal model standards; effective dates; medicare supplemental policy and State regulatory program meeting applicable standards.

(1) (A) If, within the 90-day period beginning on the date of the enactment of this subsection [enacted Dec. 13, 1989], the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the "Association") revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) referred to as the "revised NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

(2) (A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as "revised Federal model standards") for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n))--

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the

case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(n) Transition compliance with revision of NAIC Model Regulation and Federal model standards.

(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State--

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term "transition deadline" means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

(2) The transition provision described in this paragraph is--

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this title [42 USCS § § 1395 et seq.] made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before the date of the enactment of this subsection [enacted Dec. 13, 1989].

(4) (A) The date specified in this paragraph for a policy issued in a State is--

(i) the first date a State adopts, after the date of the enactment of this subsection, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B), whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as--

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph 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 January 1, 1990. 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.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title [42 USCS § § 1395 et seq.] and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains--

(A) the changes in benefits under this title [42 USCS § § 1395 et seq.] effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

(6) (A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enactment of this subsection [enacted Dec. 13, 1989], no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer--

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstatement of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of the date of the enactment of this subsection, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(o) Requirements of group benefits; core group benefits; uniform outline of coverage. The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p).

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

(p) Standards for group benefits.

(1) (A) If, within 9 months after the date of the enactment of this subsection [enacted Nov. 5, 1990], the National Association of Insurance Commissioners (in this subsection referred to as the "Association") changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate--

(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the "1991 NAIC Model Regulation").

(B) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in subparagraph (A), the

Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the "1991 Federal Regulation").

(C) (i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 1991 NAIC Model Regulation or 1991 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as--

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1991 NAIC Model Regulation or 1991 Federal Regulation, but

(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph 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 January 1, 1992. 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.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under this title [42 USCS § § 1395 et seq.] are changed and the Secretary determines, in consultation with the Association, that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the 1991 NAIC Model Regulation or 1991 Federal Regulation shall provide--

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies, [;] and

(C) that, subject to paragraph (4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10 plus the 2 plans described in paragraph (11)(A).

(3) The benefits under paragraph (2) shall, to the extent possible--

(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of the date of the enactment of this subsection; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4) (A) (i) Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval

by the Secretary unless such grouping meets the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5) (A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards described in clauses (i) through (iii) of paragraph (1)(A) in those States that on the date of enactment of this subsection had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholders or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A) is subject to a civil money penalty of not to exceed \$ 25,000 (or \$ 15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(9) (A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 1991 NAIC Model Regulation or 1991 Federal Regulation under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed \$ 25,000 (or \$ 15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with paragraph (1)(A)(i).

(11) (A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

(i) The benefit package classified as "F" under the standards established by such paragraph, except that it has a high deductible feature.

(ii) The benefit package classified as "J" under the standards established by such paragraph, except that it has a high deductible feature.

(B) For purposes of subparagraph (A), a high deductible feature is one which--

(i) requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

(ii) covers 100 percent of covered out-of-pocket expenses once such deductible has been satisfied in a year.

(C) The amount specified in this subparagraph--

(i) for 1998 and 1999 is \$ 1,500, and

(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year. If any amount determined under clause (ii) is not a multiple of \$ 10, it shall be rounded to the nearest multiple of \$ 10.

(q) Requirements. The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and--

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (4), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)--

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets [meet] the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall--

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, [the] issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) (A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX [42 USCS § § 1396 et seq.], but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstated (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under title XIX [42 USCS § § 1396 et seq.], to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such title.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph or paragraph (6) is subject to a civil money penalty of not to exceed \$ 25,000 for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence

of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(6) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) [42 USCS § 426(b)] and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) [42 USCS § 1395y(b)(1)(A)(v)]). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstated (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss.

(r) Loss ratio of aggregate benefits to aggregate premiums.

(1) A medicare supplemental policy may not be issued or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C)) in any State unless--

(A) the policy can be expected for periods after the effective date of these provisions (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A), treating policies of the same type as a single policy for each standard package.

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994 [note to this section].

(2) (A) Paragraph (1)(B) shall be applied with respect to each type of policy by standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994 [note to this section].

(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the calendar year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a calendar year, not later than the third quarter of the succeeding calendar year.

(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

(4) The Secretary shall submit in October of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disallowance of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss ratios). Such report shall include a list of the policies that failed to comply with such loss ratio requirements or other requirements of this section.

(5) (A) The Comptroller General shall periodically, not less often than once every 3 years, perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved and to the Secretary.

(B) The Secretary may independently perform such compliance audits.

(6) (A) A person who fails to provide refunds or credits as required in paragraph (1)(B) is subject to a civil money penalty of not to exceed \$ 25,000 for each policy issued for which such failure occurred. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to the policyholder or, in the case of a group policy, to the certificate holder for credits required under such paragraph.

(s) Coverage for pre-existing conditions.

(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2) (A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in, the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during 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 [42 USCS § § 1395j et seq.].

(B) Subject to subparagraphs (C) and (D), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act [42 USCS § 300gg]) of--

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date. The Secretary shall specify the manner of the reduction under clause (ii), based

upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act [42 USCS § 300gg(a)(3)].

(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) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

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

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the period specified in subparagraph (E) and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

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

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title [42 USCS § § 1395 et seq.] and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

(ii) The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice plan under part C [42 USCS § § 1395w-21 et seq.], and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1851(e)(4) [42 USCS § 1395w-21(e)(4)] or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894 [42 USCS § 1395eee], and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare + Choice plan.

(iii) The individual is enrolled with an eligible organization under a contract under section 1876 [42 USCS § 1395mm], a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1833(a)(1)(A) [42 USCS § 1395l(a)(1)(A)], or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1851(e)(4) [42 USCS § 1395w-21(e)(4)] and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because--

(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

(v) The individual--

(I) was enrolled under a medicare supplemental policy under this section,

(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under part C [42 USCS § § 1395w-21 et seq.], any eligible organization under a contract under section 1876 [42 USCS § 1395mm], any similar organization operating under demonstration project authority, any PACE provider

under section 1894 [42 USCS § 1395eee], or any policy described in subsection (t), and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) [42 USCS § 1395w-21(e)]).

(vi) The individual, upon first becoming eligible for benefits under part A [42 USCS § § 1395c et seq.] at age 65, enrolls in a Medicare + Choice plan under part C [42 USCS § § 1395w-21 et seq.] or in a PACE program under section 1894 [42 USCS § 1395eee], and disenrolls from such plan or such program by not later than 12 months after the effective date of such enrollment.

(C)

(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as "A", "B", "C", or "F" under the standards established under subsection (p)(2).

(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

(iii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

(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 under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

(E) For purposes of subparagraph (A), the time period specified in this subparagraph is--

(i) in the case of an individual described in subparagraph (B)(i), the period beginning on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if no such notice is received, notice that a claim has been denied because of such a termination or cessation) and ending on the date that is 63 days after the applicable notice;

(ii) in the case of an individual described in clause (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment is terminated involuntarily, the period beginning on the date that the individual receives a notice of termination and ending on the date that is 63 days after the date the applicable coverage is terminated;

(iii) in the case of an individual described in subparagraph (B)(iv)(I), the period beginning on the earlier of (I) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (II) the date that the applicable coverage is terminated, and ending on the date that is 63 days after the date the coverage is terminated;

(iv) in the case of an individual described in clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B) who disenrolls voluntarily, the period beginning on the date that is 60 days before the effective date of the disenrollment and ending on the date that is 63 days after such effective date; and

(v) in the case of an individual described in subparagraph (B) but not described in the preceding provisions of this subparagraph, the period beginning on the effective date of the disenrollment and ending on the date that is 63 days after such effective date.

(F) (i) Subject to clause (ii), for purposes of this paragraph--

(I) in the case of an individual described in subparagraph (B) (v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first 12 months of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

(ii) For purposes of clauses (v) and (vi) of subparagraph (B), no enrollment of an individual with an organization or provider described in clause (v) (II), or with a plan or in a program described in clause (vi), may be deemed to be an initial enrollment under this clause after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(4) Any issuer of a medicare supplemental policy that fails to meet the requirements of this subsection is subject to a civil money penalty of not to exceed \$ 5,000 for each such failure. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(t) Medicare select policies [Caution: For application and termination of this subsection, see § 4358(c) of Act Nov. 5, 1990, P.L. 101-508, which appears as a note to this section.]

(1) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if--

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

(E) (i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation without reference to this subsection and the premium charged for such policy, and

(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation and other requirements of this section without reference to this subsection.

(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)--

(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

(B) imposes premiums on enrollees in excess of the premiums approved by the State,

(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

the issuer is subject to a civil money penalty in an amount not to exceed \$ 25,000 for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to individuals entitled to benefits under this title [42 USCS § § 1395 et seq.] and under that policy) are not allowable under section 1862(a)(1) [42 USCS § 1395y(a)(1)]. Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1842(b) [42 USCS § 1395u(b)] shall apply to the entity.

(u) Additional rules relating to MSA plans and private fee-for-service plans.

(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 [42 USCS § 1395w-21] an election of an MSA plan or a Medicare + Choice private fee-for-service plan.

(2) (A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

(B) A policy described in this subparagraph is any of the following:

(i) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(ii) A policy of insurance to which substantially all of the coverage relates to--

(I) liabilities incurred under workers' compensation laws,

(II) tort liabilities,

(III) liabilities relating to ownership or use of property, or

(IV) such other similar liabilities as the Secretary may specify by regulations.

(iii) A policy of insurance that provides coverage for a specified disease or illness.

(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.

HISTORY: (Aug. 14, 1935, ch 531, Title XVIII, Part D[C], § 1882, as added June 9, 1980, P.L. 96-265, Title V, § 507(a), 94 Stat. 476; Aug. 18, 1987, P.L. 100-93, § 13, 101 Stat. 697; Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 3, Subpt. D, § 4081(b), 101 Stat. 1330-126; July 1, 1988, P.L. 100-360, Title II, Subtitle C, § 221(a)-(f) Title IV, Subtitle B, § 411(i)(1)(B), (C), Subtitle C, § 428(b), 102 Stat. 742, 788, 817; Dec. 13, 1989, P.L. 101-234, Title II, § 203(a), 103 Stat. 1981; Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle B, Part 4, § 4207(k)(1), Part 5, § § 4351-4353(d)(1), 4354(a), (b), 4355(a)-(c), 4356(a), 4357(a), 4358(a), (b)(1), (2), 104 Stat. 1388-124, 1388-

125-1388-137; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle C, § 160(d)(4), Subtitle D, § 171(a)-(d)(3)(B), (4), (e)(1), (2), (f)(1), (g), (h)(1), (j)(2), (k), 108 Stat. 4444, 4448, 4449, 4451; Aug. 21, 1996, P.L. 104-191, Title II, Subtitle G, § 271(a), (b), 110 Stat. 2034; Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 1, Subch A, §§ 4001, 4002(j)(2), 4003, Ch 4, §§ 4031(a)-(c), 4032(a), 111 Stat. 275, 330, 355, 359; Nov. 10, 1998, P.L. 105-362, Title VI, § 601(b)(6), 112 Stat. 3286; Nov. 29, 1999, P.L. 106-113, Div B, § 1000(a)(6), 113 Stat. 1536; Dec. 17, 1999, P.L. 106-170, Title II, § 205(a), 113 Stat. 1899; Dec. 21, 2000, P.L. 106-554, § 1(a)(6), 114 Stat. 2763.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

The "Medicare Catastrophic Coverage Act of 1988", referred to in subsecs. (k)(1)(A), (2)(A) and (l)(4)(A), is Act July 1, 1988, P.L. 100-360. For full classification of such Act, consult USCS Tables volumes.

The "Medicare Catastrophic Coverage Repeal Act of 1989", referred to in subsecs. (m) and (n), is Act Dec. 13, 1989, P.L. 101-234, which repealed Act July 1, 1988, P.L. 100-360. For full classification of such Act, consult USCS Tables volumes.

The "Omnibus Budget Reconciliation Act of 1990", referred to in subsec. (p)(1)(A)(iv), is Act Nov. 5, 1990, P.L. 101-508. For full classification of such Act, consult USCS Tables volumes.

With respect to the Committee on Energy and Commerce of the House of Representatives, referred to in this section, § 1(a)(4), (c)(1) of Act June 3, 1995, P.L. 104-14, which appears as a note preceding 2 USCS § 21, provides that any reference to such Committee in any provision of law enacted before January 4, 1995, shall be treated as referring to the Committee on Commerce of the House of Representatives, except that it shall be treated as referring to (A) the Committee on Agriculture of the House of Representatives, in the case of a provision of law relating to inspection of seafood or seafood products, (B) the Committee on Banking and Financial Services of the House of Representatives, in the case of a provision of law relating to bank capital markets activities generally or to depository institution securities activities generally, and (C) the Committee on Transportation and Infrastructure of the House of Representatives, in the case of a provision of law relating to railroads, railway labor, or railroad retirement and unemployment (except revenue measures related thereto).

Explanatory notes:

The bracketed comma has been inserted in subsec. (d)(3)(A)(i)(II) to indicate the probable intent of Congress to include such punctuation.

The bracketed word "issuer's" has been inserted in subsec. (d)(3)(B)(iii)(II) as the word probably intended by Congress.

The bracketed word "supplemental" has been inserted in subsec. (g)(2)(A) as the word probably intended by Congress.

The bracketed words "Committee on Energy and Commerce" have been inserted in subsec. (i)(2)(B) on the authority of H. Res. No. 549 of March 25, 1980, which redesignated the Committee on Interstate and Foreign Commerce of the House of Representatives as the Committee on Energy and Commerce.

The bracketed semicolon in subsec. (p)(2)(B) has been inserted as the punctuation probably intended by Congress.

The bracketed word "meet" has been inserted in subsec. (q)(2)(B) as the word probably intended by Congress.

The bracketed word "the" has been inserted in subsec. (q)(4) to indicate the probable intent of Congress to include such word.

The amendments made by § 1000(a)(6) of Act Nov. 29, 1999, P.L. 106-113, are based on § 321(k)(13) and (14) of Subtitle C of Title III and §§ 501(a)(2) of Subtitle A and 536(a) of Subtitle C of Title V of H.R. 3426 (113 Stat. 1501A-368, 378, 390), as introduced on Nov. 17, 1999, which was enacted into law by such § 1000(a)(6).

The amendments made by § 1(a)(6) of Act Dec. 21, 2000, P.L. 106-554, are based on § 618 of Subtitle B of Title VI of H.R. 5661 (114 Stat. 2763A-562), as introduced on Dec. 14, 2000, which was enacted into law by such § 1(a)(6).

Effective date of section:

Act June 9, 1980, P.L. 96-265, Title V, § 507(b), 94 Stat. 481, provides: "The amendment made by this section [adding this section] shall become effective on the date of the enactment, except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act [subsec. (d)(4) of this section] (as added by this section) shall become effective on July 1, 1982."

Amendments:

1987. Act Aug. 18, 1987 (effective as provided by § 15 of such Act, which appears as 42 USCS § 1320a-7 note), in subsec. (d)(1), substituted "knowingly and willfully" for "knowingly or willfully".

Act Dec. 22, 1987 (applicable as provided by § 4081(c)(2) of such Act, which appears as a note to this section), in subsec. (b), in para. (1), substituted subpara. (B) for one which read: "includes requirements equal to or more stringent than the requirements described in paragraphs (2) and (3) of subsection (c);", in subpara. (C), inserted "and", and added subpara. (D); and, in subsec. (c), in para. (1), deleted "and" following "Standards;", in para. (2), substituted "; and" for the concluding period, and added para. (3).

Such Act further (applicable as provided by § 4081(c)(2) of such Act, which appears as a note to this section), as amended July 1, 1988 (effective as if included in Act Dec. 22, 1987, P.L. 100-203 amendments as provided by § 411(a)(2) of Act July 1, 1988, which appears as 1 USCS § 106 note), in subsec. (c), in the introductory matter, inserted "(or with respect to paragraph (3), the issuer of the policy)."

1988. Act July 1, 1988 (effective as if included in Act Dec. 22, 1987, P.L. 100-203 amendments as provided by § 411(a)(2) of Act July 1, 1988, which appears as 1 USCS § 106 note), in subsec. (c), in para. (3), in subpara. (A), substituted "claim form" for "claims form" preceding "for benefits" and preceding "otherwise" and substituted "notice" for "claims form" preceding the concluding semicolon, in subpara. (B), in cl. (i), inserted "under the policy" and, in cl. (ii), substituted "payment covered by such policy" for "appropriate payment".

Such Act further (effective on enactment and applicable as provided by § 428(c) of such Act, which appears as 42 USCS § 1320b-10 note), in subsec. (d), paras. (1), (2), (3)(A, and (4)(A), substituted "shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$ 5,000 for each such prohibited act" for "shall be guilty of a felony and upon conviction thereof shall be fined not more than \$ 25,000 or imprisoned for not more than 5 years, or both", and added para. (5).

Such Act further (effective and applicable as provided by § 221(g) of such Act, which appears as a note to this section), in subsec. (a), substituted "Subject to subsection (k)(3), such certification" for "Such certification" in subsec. (b), in para. (1), in subpara. (B), substituted "and (3)", "through (4)" for redesignated former subparas. (C) and (D) as subparas. (D) and (E), respectively, and added new subpara. (C), in subpara. (D) as redesignated, substituted "(A), (B), and (C)" for "(A) and (B)", and, in the concluding matter of subsec. (b), substituted "(subject to subsection (k)(3), for so long as" for "(for so long as"; in para (2)(A), substituted "appointed by the Secretary" for "appointed by the President", and added para. (3); in subsection (c), deleted "and" following "policies;", in para. (3), substituted "; and" for the concluding period, and added para. (4); in subsec. (e), designated the existing provisions as para. (1), and added paras. (2) and (3); and added subsecs. (k) and (l).

1989. Act Dec. 13, 1989 (effective 1/1/90 as provided by § 203(e) of such Act, which appears as a note to this section), in subsecs. (a) and (b)(1), concluding matter, substituted "subsections (k)(3), (k)(4), (m) and (n)" for "subsection (k)(3)"; in subsec. (k), in para. (1)(A), inserted "except as provided in subsection (m),", and in para. (3), substituted "subsections (1), (m), and (n)" for "subsection (1)"; and added subsecs. (m) and (n).

1990. Act Nov. 5, 1990, § 4207(k)(1), as amended by Act Oct. 31, 1994, in subsecs. (a) and (b)(1), deleted "(k)(4)" following "(k)(3),".

Section 4351 of such Act, in subsec. (b)(1)(B), substituted "through (5)" for "through (4)"; in subsec. (c), in para. (3)(E), deleted "and" following the semicolon, in para. (4), substituted "; and" for the concluding period, and added para. (5); and added subsecs. (o) and (p).

Section 4352 of such Act added subsec. (q).

Section 4353(a)-(c) of such Act, in the section heading, deleted "Voluntary" preceding "certification"; in subsec. (a), designated the existing provisions as para. (1) and added para. (2); in subsec. (b), in para. (1), in the introductory matter, substituted "the Secretary" for "Supplemental Health Insurance Panel (established under paragraph (2))", in subpara. (A), inserted "and enforcement", in subpara. (D), inserted "and enforcement" and deleted "and" following "State,", in subpara. (E), inserted "and" following "provided)," and added subpara. (F), and in the concluding matter, substituted "the Secretary" for "the Panel" and added the sentence beginning "The report required under . . .", and substituted para. (2) for one which read:

"(2)

(A) There is hereby established a panel (hereinafter in this section referred to as the 'Panel') to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the Secretary and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

"(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

"(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

"(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph.

"(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code."

Section 4353(d)(1) of such Act (applicable to policies mailed, or caused to be mailed, on and after 7/1/91, as provided by § 4353(d)(2) of such Act, which appears as a note to this section), in subsec. (d)(4)(B), deleted "For purposes of this paragraph, a medicare supplemental policy shall be deemed to be approved by the commissioner or superintendent of insurance of a State if--

"(i) the policy has been certified by the Secretary pursuant to subsection (c) or was issued in a State with an approved regulatory program (as defined in subsection (g)(2)(B));

"(ii) the policy has been approved by the commissioners or superintendents of insurance in States in which more than 30 percent of such policies are sold; or

"(iii) the State has in effect a law which the commissioner or superintendent of insurance of the State has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy;

except that such a policy shall not be deemed to be approved by a State commissioner or superintendent of insurance if the State notifies the Secretary that such policy has been submitted for approval to the State and has been specifically disapproved by such State after providing appropriate notice and opportunity for hearing pursuant to the procedures (if any) of the State."

following "or superintendent of insurance."

Section 4354(a), (b) of such Act (applicable to policies issued or sold more than 1 year after enactment, as provided by § 4354(c) of such Act, which appears as a note to this section), in subsec. (d)(3), in subpara. (A), substituted "It is unlawful for a person to sell or issue" for "Whoever knowingly sells", deleted "substantially" preceding "duplicates health benefits", substituted ". Whoever violates the previous sentence shall be fined" for ", shall be fined", inserted "or title XIX", substituted "\$ 25,000 (or \$ 15,000 in the case of a person other than the issuer of the policy)" for "\$ 5,000" and added the sentences beginning "A seller (who is not . . ." and "This subsection shall not . . .", and substituted subpara. (B) for one which read:

"For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative."; and, in subsec. (q), added para. (5).

Section 4355(a)-(c) of such Act (applicable as provided by § 4355(d) of such Act, which appears as a note to this section), in subsec. (b)(1), in subpara. (C), in cl. (ii), substituted a comma for the semicolon, and added the concluding matter, in subpara. (E), deleted "and" following "provided)", in subpara. (F), added "and" following the comma, and added subpara. (G); in subsec. (c), substituted para. (2) for one which read: "can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies"; and deleted the concluding matter which read: "For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies."; and added subsec. (r).

Section 4356(a) of such Act (effective on enactment as provided by § 4356(b) of such Act, which appears as a note to this section), in subsec. (g)(1), inserted "and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 or an agreement under section 1833".

Section 4357(a) of such Act (effective 1 year after enactment as provided by § 4357(b) of such Act, which appears as a note to this section), in subsec. (c), introductory matter, inserted "or the requirement described in subsection (s)"; and added subsec. (s).

Section 4358(a), (b)(1) and (2) of such Act (applicable as provided by § 4358(c) of such Act, which appears as a note to this section), in subsec. (b)(1), in subpara. (A), inserted ", except as otherwise provided by subparagraph (H)", in subpara. (F), deleted "and" following the comma, in subpara. (G), inserted "and" following the comma, and added subpara. (H); in subsec. (c)(1), inserted "(except as otherwise provided by subsection (t))"; and added subsec. (t).

1994. Act Oct. 31, 1994, § 161(d)(2), made a technical correction to § 4207 of Act Nov. 5, 1990, which did not affect the text of this section.

Section 171(a)(1) of such Act (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 171(1) of the 1994 Act, which appears as a note to this section) made a technical correction to § 4351 of Act Nov. 5, 1990, which did not affect the text of this section.

Section 171(a)(2), (b), and (c) (effective as above), in subsec. (a)(2), in subpara. (A), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC standards or the Federal standards" and, in the concluding matter, substituted "on and after the effective date specified in subsection (p)(1)(C)" for "after the effective date of the NAIC or Federal standards with respect to the policy"; in subsec. (b)(1), in the introductory matter, substituted "the Secretary" for "the the Secretary" and, in the concluding sentence, substituted "Each report" for "The report", inserted "and requirements", deleted "and" after "compliance,", and deleted a comma after "Commissioners"; and, in subsec. (g)(2)(B), substituted "Secretary" for "Panel"; in subsec. (p)(1), in subpara. (A), in the introductory matter, substituted "changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate" for "promulgates", in the concluding matter, deleted "(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards')", preceding "subsection (g)(2)(A)" and substituted "were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '1991 NAIC Model Regulation')" for "included a reference to the NAIC standards", in subpara. (B), substituted "make the changes in the revised NAIC Model Regulation" for "promulgate NAIC standards",

substituted "a regulation" for "limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards')", and substituted "were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '1991 Federal Regulation')" for "included a reference to the Federal standards", in subpara. (C), in cl. (i), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC standards or the Federal standards" and, in cl. (ii)(I), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards", in subpara. (E), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards", and, in para. (2), in the introductory matter, substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards" and, in subpara. (C), substituted "(4)(B)" for "(5)(B)", in para. (4), in subpara. (A), in cl. (i), inserted "or paragraph (6)" and substituted "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation" for "applicable standards" and, in cl. (ii), substituted "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation" for "applicable standards" and, in subpara. (B), substituted "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation" for "applicable standards", in para. (6), substituted "described in clauses (i) through (iii) of paragraph (1)(A)" for "in regard to the limitation of benefits described in paragraph (4)", in para. (7), substituted "policyholders" for "policyholder", in para. (8), substituted "on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)" for "after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection", in para. (9), in subpara. (B), substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC or Federal standards", and added subpara. (D), and in para. (10), substituted "paragraph (1)(A)(i)" for "this subsection"; and, in subsec. (q), in para. (2), substituted "paragraph (4)" for "paragraph (2)" and, in para. (4), substituted "issuer of the replacement policy" for "the succeeding issuer".

Section 171(d)(1) of such Act (effective and applicable as provided by § 171(1)(1) of such Act, which appears as a note to this section), in subsec. (d)(3)(A), substituted cl. (i) for "It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title or title XIX).", designated the sentence beginning "Whoever violates . . ." as cl. (ii) and, in such clause, substituted "clause (i)" for "the previous sentence", designated the sentence beginning "A seller . . ." as cl. (iii) and, in such clause, substituted "clause (i) with respect to the sale of a medicare supplemental policy" for "the previous sentence" and deleted "and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p)." following "subparagraph (B)".

Section 171(d)(2)(A) of such Act (effective as provided by § 171(1)(2) of such Act, which appears as a note to this section), in subsec. (d)(3)(B)(ii)(II), deleted "65 years of age or older" preceding "may be".

Section 171(d)(2)(B)-(E), (3), and (4) of such Act (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 171(1) of the 1994 Act, which appears as a note to this section), in subsec. (d)(3), in subpara. (B)(iii), in subcl. (I), substituted "a medicare" for "another medicare" and substituted "a medicare supplemental policy" for "such a policy", in subcl. (II), substituted "a medicare supplemental policy" for "another policy", and substituted subcl. (III) for one which read: "Subclause (I) also shall not apply if a State medicaid plan under title XIX pays the premiums for the policy, or

pays less than an individual's (who is described in section 1905(p)(1)) full liability for medicare cost sharing as defined in section 1905(p)(3)(A).", in subpara. (C), substituted "(i) the sale or issuance" for "the selling" and inserted a comma and cls. (ii) and (iii), and added subpara. (D); and, in subsec. (q)(5), in subparas. (A) and (B), deleted "of the Social Security Act" following "title XIX".

Section 171(e)(1)(A), (B), and (E) (effective as provided by § 171(l)(2) of such Act, which appears as a note to this section), in subsec. (r), in para. (1), in the introductory matter, substituted "or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))" for "or sold", in subpara. (A), inserted "for periods after the effective date of these provisions" and, in the concluding matter, added the sentence beginning "For the purpose of calculating the refund . . .".

Section 171(e)(1)(C), (D), (F)-(M), and (2) of such Act (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 171(l) of the 1994 Act, which appears as a note to this section), in subsec. (b), in the concluding matter, substituted "subparagraph (F)" for "subsection (F)"; in subsec. (r), in para. (1), in subpara. (A), substituted "Commissioners)" for "Commissioners," and, in subpara. (B), inserted ", treating policies of the same type as a single policy for each standard package", in para. (2), in subpara. (A), substituted "by standard package" for "policy number", substituted "Paragraph (1)(B) shall not apply to a policy until 12 months following issue." for "Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect.", deleted "in order to apply paragraph (1)(B) to the first 2 years in which policies are effective" following "appropriate", and added "In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994." and, in subparas. (C) and (D), substituted "calendar year" for "policy year" wherever appearing, in para. (4), substituted "October" for "February", substituted "disallowance" for "disallowance", substituted "loss ratios" for "loss-ratios" in two places, and substituted "loss ratio" for "loss-ratio", in para. (6), in subpara. (A), substituted "fails to provide refunds or credits as required in paragraph (1)(B)" for "issues a policy in violation of the loss ratio requirements of this subsection" and substituted "policy issued for which such failure occurred" for "such violation" and, in subpara. (B), substituted "to the policyholder or, in the case of a group policy, to the certificate holder" for "to policyholders".

Section 171(f), (g)(1) of such Act (effective as above), in subsec. (g)(1), substituted "an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A)" for "a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 or an agreement under section 1833"; and, in subsec. (s)(2)(A), substituted "in the case of an individual for whom an application is submitted prior to or" for "for which an application is submitted".

Section 171(g)(2) of such Act (effective 1/1/95 and applicable as provided by § 171(l)(3) of such Act, which appears as a note to this section), in subsec. (s)(2)(A), substituted "as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B" for "in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B".

Section 171(g)(3), (h)(1), (j)(2), and (k) of such Act (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 171(l) of the 1994 Act, which appears as a note to this section), in subsec. (d)(4), in subpara. (D), deleted ", if such policy expires not more than 12 months after the date on which the duplicate copy is mailed" following "is mailed", and added subpara. (E); in subsec. (f), added para. (3); in subsec. (s)(2)(B), substituted

"before the policy" for "before it"; in subsec. (t), in para. (1), in the introductory matter, inserted "medicare supplemental" and substituted "1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC Model Standards", in subpara. (A), inserted "or agreements" and, in subparas. (E)(i) and (F), substituted "standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation" for "NAIC standards" and, in para. (2), in the concluding matter, inserted "the issuer".

1996. Act Aug. 21, 1996 (effective and applicable as provided by § 271(d) of such Act, which appears as a note to this section), in subsec. (d)(3)(A), in cl. (iii), substituted "clause (i)(II)" for "clause (iii)", and added cls. (iv)-(viii).

Such Act further, in subsec. (d)(3), in subpara. (C), substituted "with respect to" for "with respect to (i)", and deleted ", (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual" following "of the labor organizations", and deleted subpara. (D), which read:

"(D)

(i) If--

"(I) within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) and submits to the Secretary a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and

"(II) the Secretary approves all the statements submitted as meeting the requirements of subclause (I),

each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved. The Secretary shall review and approve (or disapprove) all the statements submitted under subclause (I) within 30 days after the date of their submittal. Upon approval of such statements, the Secretary shall publish such statements.

"(ii) If the Secretary does not approve the statements under clause (i) or the statements are not submitted within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the date of disapproval or the end of such 90-day period (as the case may be)) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved."

1997. Act Aug. 5, 1997, in subsec. (d)(3), in subpara. (A)(i), in the introductory matter, inserted "(including an individual electing a Medicare + Choice plan under section 1851)" and, in subcl. (II), inserted "in the case of an individual not electing a Medicare + Choice plan" and "or in the case of an individual electing a Medicare + Choice plan, a medicare supplemental policy

with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare + Choice plan or under another medicare supplemental policy" and, in subpara. (B)(i)(I), inserted "(including any Medicare + Choice plan)"; in subsec. (g)(1), inserted "or a Medicare + Choice plan or"; and added subsec. (u).

Such Act further (effective January 1, 1999, as provided by § 4002(j)(2) of such Act), in subsec. (g)(1), deleted ", during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995," preceding "a policy or plan of an organization".

Such Act further (effective as if included in Act Aug. 21, 1996, pursuant to § 4031(d)(3) of Act Aug. 5, 1997, which appears as a note to this section), in subsec. (d)(2)(A)(vi)(III), inserted ", a policy described in clause (v),".

Such Act further (applicable to policies issued on or after 7/1/98, as provided by § 4031(d)(2) which appears as a note to this section), in subsec. (s)(2), in subpara. (B), substituted "subparagraphs (C) and (D)" for "subparagraph (C)", and added subpara. (D).

Such Act further (effective on enactment as provided by § 4032(b), which appears as a note to this section), in subsec. (p), in para. (2)(C), inserted "plus the 2 plans described in paragraph (11)(A)", and added para. (11).

Such Act further (effective 7/1/98, as provided by § 4031(d)(1) of such Act, which appears as a note to this section), in subsec. (s), in para. (3), substituted "this subsection" for "paragraphs (1) and (2)", redesignated para. (3) as para. (4), and added new para. (3).

1998. Act Nov. 10, 1998, in subsec. (1), repealed para. (6), which read: "(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).".

1999. Act Nov. 29, 1999 (effective as if included in the enactment of Act Aug. 5, 1997, as provided by § 321(m) of H.R. 3426, as enacted into law by Act Nov. 29, 1999, which appears as 42 USCS § 1395d note), in subsec. (g)(1), deleted "or" following "does not include"; and, in subsec. (s)(2)(D), in the introductory matter, inserted "section".

Such Act further (applicable as provided by § 501(d)(1) of H.R. 3426, as enacted into law by such Act, which appears as 42 USCS § 1395w-21 note), in subsec. (s)(3), in subpara. (A), in the concluding matter, inserted ", subject to subparagraph (B) who", and added subpara. (E).

Such Act further (applicable as provided by § 536(b) of H.R. 3426, as enacted into law by such Act, which appears as a note to this section), in subsec. (s)(3)(B), in cl. (ii), inserted "or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare + Choice plan", in cl. (v)(II), inserted "any PACE provider under section 1894" and, in cl. (vi), inserted "or in a PACE program under section 1894" and substituted "such plan or such program" for "such plan".

Act Dec. 17, 1999 (applicable as provided by § 205(b) of this Act, which appears as a note to this section), in subsec. (q), in para. (5)(C), inserted "or paragraph (6)", and added para. (6).

2000. Act Dec. 21, 2000, in subsec. (s)(3), in subpara. (A), in the concluding matter, substituted "seeks to enroll under the policy during the period specified in subparagraph (E)" for ", subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph", substituted subpara. (E) for one which read:

"(E)

(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare + Choice organization of the impending termination or discontinuance of the Medicare + Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

"(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph (A) shall only become effective upon termination of coverage under the Medicare + Choice plan involved.",

and added subpara. (F).

Redesignation:

Act Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 1, Subch A, § 4001, 111 Stat. 275, redesignated Part C of Title XVIII of Act Aug. 14, 1935, ch 531, as Part D of such Title.

Other provisions:

Applicability of Dec. 22, 1987 amendments. Act Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 3, Subpt. D, § 4081(c)(2), 101 Stat. 1330-128, as amended July 1, 1988, P.L. 100-360, Title IV, Subtitle B, § 411(i)(1)(E), 102 Stat. 788, applicable as if included in Act Dec. 22, 1987 amendment, as provided by § 411(a)(2) of the 1988 Act which appears as 1 USCS § 106 note; Oct. 13, 1988, P.L. 100-485, Title VI, § 608(d)(24)(A), 102 Stat. 2421, effective as if included in Act July 1, 1988, P.L. 100-360 as provided by § 608(g) of the later 1988 Act, which appears as 42 USCS § 704 note, provides:

"(A) The amendments made by subsection (b) [amending subsecs. (b) and (c) of this section] shall apply to medicare supplemental policies as of January 1, 1989 (or, if applicable, the date established under subparagraph (B)).

"(B) In the case of a State which the Secretary of Health and Human Services identifies as--

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to be changed to meet the requirements of section 1882(c)(3) of the Social Security Act [subsec. (c)(3) of this section], and

"(ii) having a legislature which is not scheduled to meet in 1988 in a legislative session in which such legislation may be considered or which has not enacted such legislation before July 1, 1988,

the date specified in this subparagraph 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 January 1, 1989, and in which legislation described in clause (i) may be considered."

Effective date and applicability of July 1, 1988 amendments. Act July 1, 1988, P.L. 100-360, Title II, Subtitle C, § 221(g), 102 Stat. 746; Oct. 13, 1988, P.L. 100-485, Title VI, § 608(d)(12), 102 Stat. 2415, effective as if included in Act July 1, 1988, P.L. 100-360 as provided by § 608(g) of the later 1988 Act, which appears as 42 USCS § 704 note; Dec. 13, 1989, P.L. 101-234, Title II, § 203(d), 103 Stat. 1985, effective as if included in Act July 1, 1988, P.L. 100-360, as provided by § 203(e) of the 1989 Act, which appears as a note to this section, provides:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act.

"(2) The amendments made by subsections (a) and (b) [amending subsecs. (b) and (c) of this section] shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act [subsecs. (k)(1)(B), (k)(2)(B) of this section] (as added by subsection (d) of this section).

"(3) The amendment made by subsection (e) [adding subsec. (b)(3) to this section] shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

"(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act [subsec. (b)(2) of this section] by not later than 90 days after the date of the enactment of this Act."

Effective date of Dec. 13, 1989 amendments. Act Dec. 13, 1989, P.L. 101-234, Title II, § 203(e), 103 Stat. 1985, provides: "The provisions of this section [amending this section; 42 USCS § § 1395b-2 note, 1395mm note, and notes to this section] shall take effect January 1, 1990, except that the amendment made

by subsection (d) [amending 42 USCS § 1395ss note] shall be effective as if included in the enactment of MCCA [Act July 1, 1988, P.L. 100-360]."

Applicability of amendments made by § 4353 of Act Nov. 5, 1990. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 4, § 4353(d)(2), 104 Stat. 1388-130, provides: "The amendment made by paragraph (1) [amending subsec. (d)(4)(B) of this section] shall apply to policies mailed, or caused to be mailed, on and after July 1, 1991."

Applicability of amendments made by § 4354 of Act Nov. 5, 1990. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 5, § 4354(c), 104 Stat. 1388-132, provides: "The amendments made by this section [amending subsecs. (d) and (g) of this section] shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act."

Effective date of amendments made by § 4355 of Act Nov. 5, 1990. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 5, § 4355(d), 104 Stat. 1388-134; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle D, § 171(e)(3), 108 Stat. 4449 (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 171(1) of the 1994 Act, which appears as a note to this section), provides: "The amendments made by this section [amending this section] shall apply to policies issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act [subsec. (p)(1)(C) of this section]) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act [subsec. (p)(1)(C) of this section]."

Effective date of amendment made by § 4356 of Act Nov. 5, 1990. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 5, § 4356(b), 104 Stat. 1388-134; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle D, § 171(f)(2), 108 Stat. 4449 (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 171(1) of the 1994 Act, which appears as a note to this section), provides: "The amendment made by subsection (a) [amending subsec. (g)(1) of this section] shall take effect on the date specified in section 1882(p)(1)(C) of the Social Security Act [subsec. (p)(1)(C) of this section]."

Effective date of amendments made by § 4357 of Act Nov. 5, 1990. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 5, § 4357(b), 104 Stat. 1388-134, provides: "The amendments made by subsection (a) [amending subsec. (c) and adding subsec. (s) to this section] shall take effect 1 year after the date of the enactment of this Act."

Applicability of amendments made by § 4358 of Act Nov. 5, 1990; study. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 4, § 4358(c), 104 Stat. 1388-137; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle D, § 172(a), 108 Stat. 4452 (effective as if included in the enactment of Act Nov. 5, 1990, as provided by § 172(b) of the 1994 Act); July 7, 1995, P.L. 104-18, § 1, 109 Stat. 192, provides:

"(1) The amendments made by this section [amending subsecs. (b)(1) and (c)(1) of this section, adding subsec. (t) of this section, and amending 42 USCS § 1320c-3] shall only apply--

"(A) in 15 States (as determined by the Secretary of Health and Human Services) and such other States as elect such amendments to apply to them, and

"(B) subject to paragraph (2), during the 6 1/2 -year period beginning with 1992.

For purposes of this paragraph, the term 'State' has the meaning given such term by section 210(h) of the Social Security Act (42 U.S.C. 410(h)).

"(2)

(A) The Secretary of Health and Human Services shall conduct a study that compares the health care costs, quality of care, and access to services under medicare select policies with that under other medicare supplemental policies. The study shall be based on surveys of appropriate age-adjusted sample populations. The study shall be completed by June 30, 1997.

"(B) Not later than December 31, 1997, the Secretary shall determine, based on the results of the study under subparagraph (A), if any of the following findings are true:

"(i) The amendments made by this section [amending subsecs. (b)(1) and (c)(1) of this section, adding subsec. (t) of this section, and amending 42 USCS § 1320c-3] have not resulted in savings of premium costs to those enrolled in medicare select policies (in comparison to their enrollment in medicare

supplemental policies that are not medicare select policies and that provide comparable coverage).

"(ii) There have been significant additional expenditures under the medicare program as a result of such amendments.

"(iii) Access to and quality of care has been significantly diminished as a result of such amendments.

"(C) The amendments made by this section [amending subsecs. (b)(1) and (c)(1) of this section, adding subsec. (t) of this section, and amending 42 USCS § 1320c-3] shall remain in effect beyond the 6 1/2 -year period described in paragraph (1)(B) unless the Secretary determines that any of the findings described in clause (i), (ii), or (iii) of subparagraph (B) are true.

"(3) The Comptroller General shall conduct a study to determine the extent to which individuals who are continuously covered under a medicare supplemental policy are subject to medical underwriting if they change the policy under which they are covered, and to identify options, if necessary, for modifying the medicare supplemental insurance market to make sure that continuously insured beneficiaries are able to switch plans without medical underwriting. By not later than June 30, 1996, the Comptroller General shall submit to the Congress a report on the study. The report shall include a description of the potential impact on the cost and availability of medicare supplemental policies of each option identified in the study."

Applicability of amendments made by § 4358 of Act Nov. 5, 1990. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 5, § 4357(b), 104 Stat. 1388-134, provides: "The amendments made by this section [for full classification, consult USCS Tables volumes] shall only apply in 15 states (as determined by the Secretary of Health and Human Services) and only during the 3-year period beginning in 1992.

Evaluation of 1990 amendments; report to Congress. Act Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 5, § 4358(c), 104 Stat. 1388-137, provides: "The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section [amending this section and 42 USCS § 1320c-3] and shall report to Congress on such evaluation by not later than January 1, 1995."

Applicability of disclosure requirement of subsec. (d)(3)(C)(ii). Act Oct. 31, 1994, P.L. 103-432, Title I, Subtitle D, § 171(d)(3)(C), 108 Stat. 4448, provides: "The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act [subsec. (d)(3)(C)(ii) of this section] shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act [subsec. (d)(3)(D) of this section]."

Effective date and applicability of amendments made by § 171 of Act Oct. 31, 1994. Act Oct. 31, 1994, P.L. 103-432, Title I, Subtitle D, § 171(1), 108 Stat. 4451, provides:

"The amendments made by this section [for full classification, consult USCS Tables volumes] shall be effective as if included in the enactment of OBRA-1990 [Act Nov. 5, 1990, P.L. 101-508, 104 Stat. 1388-1; for full classification, consult USCS Tables volumes]; except that--

"(1) the amendments made by subsection (d)(1) [amending subsec. (d)(3)(A) of this section] shall take effect on the date of the enactment of this Act, but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A) of this section] (for an action occurring after the effective date of the amendments made by section 4354 of OBRA-1990 [§ 4354 of Act Nov. 5, 1990, P.L. 101-508] and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act [subsec. (d)(3)(A)(i)(II) of this section] (as amended by this section);

"(2) the amendments made by subsection (d)(2)(A) [amending subsec. (d)(3)(B)(ii)(II) of this section] and by subparagraphs (A), (B), and (E) of subsection (e)(1) [amending subsec. (r)(1) of this section] shall be effective on the date specified in subsection (m)(4) [note to this section]; and

"(3) the amendment made by subsection (g)(2) [amending subsec. (s)(2)(A) of this section] shall take effect on January 1, 1995, and shall apply to individuals who attain 65 years of age or older on or after the effective date

of section 1882(s)(2) of the Social Security Act [subsec. (s)(2) of this section] (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, and who were not covered under such section before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995).".

Transition provisions. Act Oct. 31, 1994, P.L. 103-432, Title I, Subtitle D, § 171(m), 108 Stat. 4451, provides:

"(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 [this section] due solely to failure to make such change until the date specified in paragraph (4).

"(2) NAIC standards. If, within 6 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 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with 'unless', such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act [this 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 1991 Regulation for the purposes of section 1882 of the Social Security Act [this 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 1996 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 January 1, 1996. 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."

Transitional provision. Act Aug. 21, 1996, P.L. 104-191, Title II, Subtitle G, § 271(c), 110 Stat. 2036, provides:

"(1) No penalties. Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A) of this section] for any act or omission that occurred during the transition period (as defined in paragraph (4)) and that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

"(2) Limitation on legal action. Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action--

"(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and

"(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A) of this section] to any act or omission with

respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

"(3) Disclosure condition. In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A) of this section] that is sold or issued on or after the effective date of statements under section 171(d)(3)(C) of the Social Security Act Amendments of 1994 [§ 171(d)(3)(C) of Act Oct. 31, 1994, P.L. 103-432, which appears as a note to this section]] and before the end of the 30-day period beginning on the date of the enactment of this Act, paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act [subsec. (d)(3)(C)(ii) of this section] (as in effect before the date of the enactment of this Act).

"(4) Transition period. In this subsection, the term 'transition period' means the period beginning on November 5, 1991, and ending on the date of the enactment of this Act."

Effective date of Aug. 21, 1996 amendment of subsec. (d)(3)(A). Act Aug. 21, 1996, P.L. 104-191, Title II, Subtitle G, § 271(d), 110 Stat. 2036, provides:

"(1) Except as provided in this subsection, the amendment made by subsection (a) [amending subsec. (d)(3)(A) of this section] shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990 [§ 4354 of Act Nov. 5, 1990, P.L. 101-508, which amended this section].

"(2)

(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act [subsec. (d)(3)(A)(vi) of this section], as added by subsection (a), shall only apply to individuals applying for--

"(i) a health insurance policy described in section 1882(d)(3)(A)(iv) of such Act [subsec. (d)(3)(A)(iv) of this section] (as added by subsection (a)), after the date of the enactment of this Act, or

"(ii) another health insurance policy after the end of the 30-day period beginning on the date of the enactment of this Act.

"(B) A seller or issuer of a health insurance policy may substitute, for the disclosure statement described in clause (vii) of such section, the statement specified under section 1882(d)(3)(D) of the Social Security Act [subsec. (d)(3)(D) of this section] (as in effect before the date of the enactment of this Act), without the revision specified in such clause."

Effective date of amendment made by § 4002(j)(2) of Act Aug. 5, 1997. Act Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 1, Subch A, § 4002(j)(2), 111 Stat. 330, provides that the amendment made by such section to subsec. (g)(1) of this section is effective January 1, 1999.

Effectiveness and applicability of amendments made by § 4031(a)-(c) of Act Aug. 5, 1997. Act Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 4, § 4031(d), 111 Stat. 357, provides:

"(1) Guaranteed issue. The amendment made by subsection (a) [amending subsec. (s)(3) of this section] shall take effect on July 1, 1998.

"(2) Limit on preexisting condition exclusions. The amendment made by subsection (b) [amending subsec. (s)(2) of this section] shall apply to policies issued on or after July 1, 1998.

"(3) Conforming amendment. The amendment made by subsection (c) [amending subsec. (d)(3) of this section] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Act Aug. 21, 1996, P.L. 104-191; for full classification, consult USCS Tables volumes]."

Transition provisions. Act Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 4, § 4031(e), 111 Stat. 358, provides:

"(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 [this section] 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 [this section] (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) [note to this section] and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act [subsec. (d)(3)(A)(vi)(IV) of this section], as added by section 271(a) of the Health Insurance 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."

Conforming benefits to changes in terminology for hospital outpatient department cost sharing. Act Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 4, § 4031(f), 111 Stat. 359, provides: "For purposes of apply [applying] section 1882 of the Social Security Act (42 U.S.C. 1395ss) and regulations referred to in subsection (e) [note to this section], copayment amounts provided under section 1833(t)(5) of such Act [42 USCS § 13951(t)(5)] with respect to hospital outpatient department services shall be treated under medicare supplemental policies in the same manner as coinsurance with respect to such services."

Effective date and applicability of amendments made by § 4032(a) of Act Aug. 5, 1997. Act Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle A, Ch 4, § 4032(b), 111 Stat. 359, provides:

"(1) In general. The amendments made by subsection (a) [amending subsec. (p) of this section] shall take effect the date of the enactment of this Act.

"(2) Transition. The provisions of section 4031(e) [note to this section] shall apply with respect to this section in the same manner as they apply to section 4031 [note to this section]."

Applicability of amendments made by § 536 of H.R. 3426, as enacted into law by Act Nov. 29, 1999. Act Nov. 29, 1999, P.L. 106-113, Div B, § 1000(a)(6), 113 Stat. 1536 (enacting into law § 536(b) of Title V of Subtitle C of H.R. 3426 (113 Stat. 1501A-391), as introduced on Nov. 17, 1999), provides: "The amendments made by this section [amending subsec. (s)(3)(B) of this section] shall apply to terminations or discontinuances made on or after the date of the enactment of this Act."

Study of Medigap policies. Act Nov. 29, 1999, P.L. 106-113, Div B, § 1000(a)(6), 113 Stat. 1536 (enacting into law § 553(a) of Title V, Subtitle E of H.R. 3426 (113 Stat. 1501A-393), as introduced on Nov. 17, 1999), provides:

"(1) In general. The Comptroller General of the United States (in this section referred to as the 'Comptroller General') shall conduct a study of the issues described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

"(2) Issues to be studied. The issues described in this paragraph are the following:

"(A) The level of coverage provided by each type of medicare supplemental policy.

"(B) The current enrollment levels in each type of medicare supplemental policy.

"(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65 1/2 .

"(D) The number and type of medicare supplemental policies offered in each State.

"(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

"[(3)](2) Report. Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study."

Effective date of Dec. 17, 1999 amendments. Act Dec. 17, 1999, P.L. 106-170, Title II, § 205(b), 113 Stat. 1900, provides: "The amendments made by subsection (a) [amending subsec. (q) of this section] apply with respect to requests made after the date of the enactment of this Act."

NOTES:

CODE OF FEDERAL REGULATIONS

Officer of Inspector General-Health Care, Department of Health and Human Services--Civil money penalties, assessments, and exclusions, 42 CFR Part 1003.

CROSS REFERENCES

This section is referred to in 10 USCS § 1108; 26 USCS § 9832; 29 USCS § 1191b; 42 USCS § § 300gg-91; 1320c-3, 1320d, 1395a, 1395b-3, 1395b-4, 1395u, 1395w-21, 1395w-22, 3058k.

RESEARCH GUIDE

Federal Procedure:

30 Fed Proc L Ed, Social Security and Medicare § 71:680.

Am Jur:

70C Am Jur 2d, Social Security and Medicare § § 2342, 2377.

INTERPRETIVE NOTES AND DECISIONS

"Complete preemption" exception to well-pleaded complaint rule did not permit removal based on federal-question jurisdiction, where insureds' state-law claims for fraud, breach of fiduciary duty, and outrage against hospitalization insurer were not displaced by a federal cause of action. *Means v Independent Life & Accident Ins. Co.* (1997, MD Ala) 963 F Supp 1131.

42 USCS § 1395ss(d)(3)(A)(viii)(II) did not completely preempt insureds' state-law claims against insurer including fraud and breach of fiduciary duty, so as to permit removal by insurer based on federal question jurisdiction, since Congress did not intend complete preemption, and statute did not contain jurisdictional grant indicating complete preemption. *Cowan v Combined Ins. Co. of Am.* (1999, MD Ala) 67 F Supp 2d 1312.



STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Legal Division

BOB WISE
Governor

JANE L. CLINE
Insurance Commissioner

December 17, 2002

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Please find attached for filing one (1) copy of the following:

- 1) Notice Of A Comment Period On A Proposed Rule and consent of Tax and Revenue Cabinet Secretary;
- 2) Brief Summary of Rule;
- 3) Statement of Circumstances;
- 4) Fiscal Note; and
- 5) The proposed Rule entitled "Medicare Supplement Insurance" (Series 24).

Please contact me if further information is required.

Sincerely,

A handwritten signature in black ink that reads "Vincent J. King" followed by a stylized flourish.

Vincent J. King
General Counsel

VJK/jz
Enclosures