

Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

(8) Waiver of budget neutrality

The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this subchapter.

(c) Determinations

(1) By the Commissioner of Social Security

For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 401(g) of this title, shall determine whether individuals are environmental exposure affected individuals.

(2) By the Secretary

The Secretary shall determine eligibility for pilot programs under subsection (b).

(d) Emergency declaration defined

For purposes of this section, the term “emergency declaration” means a declaration of a public health emergency under section 9604(a) of this title.

(e) Environmental exposure affected individual defined

(1) In general

For purposes of this section, the term “environmental exposure affected individual” means—

- (A) an individual described in paragraph (2); and
- (B) an individual described in paragraph (3).

(2) Individual described

(A) In general

An individual described in this paragraph is any individual who—

- (i) is diagnosed with 1 or more conditions described in subparagraph (B);
- (ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—
 - (I) not less than 10 years prior to such diagnosis; and
 - (II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;
- (iii) files an application for benefits under this subchapter (or has an application filed on behalf of the individual), including pursuant to this section; and
- (iv) is determined under this section to meet the criteria in this subparagraph.

(B) Conditions described

For purposes of subparagraph (A), the following conditions are described in this subparagraph:

- (i) Asbestosis, pleural thickening, or pleural plaques as established by—

(I) interpretation by a “B Reader” qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(II) such other diagnostic standards as the Secretary specifies,

except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

(I) pathologic examination of biopsy tissue;

(II) cytology from bronchioalveolar lavage; or

(III) such other diagnostic standards as the Secretary specifies.

(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

(3) Other individual described

An individual described in this paragraph is any individual who—

(A) is not an individual described in paragraph (2);

(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

(D) files an application for benefits under this subchapter (or has an application filed on behalf of the individual), including pursuant to this section; and

(E) is determined under this section to meet the criteria in this paragraph.

(Aug. 14, 1935, ch. 531, title XVIII, §1881A, as added Pub. L. 111-148, title X, §10323(a), Mar. 23, 2010, 124 Stat. 954.)

Editorial Notes

REFERENCES IN TEXT

Parts A and B, referred to in subsecs. (a)(3) and (b)(2), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

§ 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 1320a-7a of this title (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 1320a-7a(a) of this title.

(b) Standards and requirements; periodic review by Secretary

(1) Any medicare supplemental policy issued in any State which the Secretary determines has established under State law a regulatory program that—

(A) 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) 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) 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 1395u(h)(3)(B) of this title 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 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1395u(h)(3)(B) of this title 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 1395u(h)(3)(B) of this title 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 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 subchapter, 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 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 or enrolled under part B of this subchapter (including an individual electing a Medicare+Choice plan under section 1395w-21 of this title)—

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this subchapter or subchapter XIX,

(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 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 vio-

late 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 subchapter, under subchapter XIX, 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 subchapter 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 subchapter 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 August 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 subchapter 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 subchapter or under another health insurance policy.

(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this subchapter 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, 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 August 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 or enrolled under part B “duplicates” health benefits under this subchapter 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 or enrolled under part B, 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 subchapter XIX, 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 subchapter XIX 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 subchapter 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 subchapter XIX, 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'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 subchapter XIX, 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 subchapter pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1396d(p)(1) of this title, 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 1396d(p)(3)(A)(ii) of this title.

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, 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 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 1320a-7a of this title (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 1320a-7a(a) of this title.

(e) Dissemination of information

(1) The Secretary shall provide to all individuals entitled to benefits under this subchapter (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 subchapter.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this subchapter (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 subchapter (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 subchapter (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 subchapter.

(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 subchapter 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 subchapter XIX 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 subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter; but does not include a prescription drug plan under part D or 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 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title 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 a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1395(a)(1)(A) of this title. 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 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 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 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 sub-

section (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 (1)¹ 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).

(l) Transitional compliance with NAIC Model Transition Regulation; "qualifying medicare supplemental policy" and "NAIC Model Transition Regulation" defined

(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

¹ So in original. Probably should be "subsection (l)".

(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 subchapter 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 subchapter 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 December 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 subchapter 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 December 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 December 13, 1989, 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 subchapter 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 subchapter 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 December 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 December 13, 1989, 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 subsections (p), (v)² (w), and (y).

(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.

(4) The issuer of the medicare supplemental policy complies with subsection (s)(2)(E) and subsection (x).

(5) In addition to the requirement under paragraph (2), the issuer of the policy must make available to the individual at least Medicare supplemental policies with benefit packages classified as "C" or "F".

(p) Standards for group benefits

(1)(A) If, within 9 months after November 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 subchapter 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

² So in original. Probably should be followed by a comma.

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 November 5, 1990; 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 November 5, 1990, 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 1320a-7a of this title (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 1320a-7a(a) of this title.

(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 1320a-7a of this title (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 1320a-7a(a) of this title.

(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) Guaranteed renewal of policies; termination; suspension

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 meets³ 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, issuer⁴ 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 enti-

led to medical assistance under subchapter XIX, 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 subchapter XIX, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such subchapter.

(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 1320a-7a of this title (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 1320a-7a(a) of this title.

(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 426(b) of this title and is covered under a group health plan (as defined in section 1395y(b)(1)(A)(v) of this title). 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) Required 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

³ So in original. Probably should be "meet".

⁴ So in original. Probably should be preceded by "the".

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.

(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.

(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) The Secretary may 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.

(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 1320a-7a of this title (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 1320a-7a(a) of this title.

(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.

(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)⁵ of the Public Health Service Act) of—

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

⁵ See References in Text note below.

(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.

(E) An issuer of a medicare supplemental policy shall not deny or condition the issuance or effectiveness of the policy (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) and shall not discriminate in the pricing of the policy (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(F) RULE OF CONSTRUCTION.—Nothing in subparagraph (E) or in subparagraphs (A) or (B) of subsection (x)(2) shall be construed to limit the ability of an issuer of a medicare supplemental policy from, to the extent otherwise permitted under this subchapter—

(i) denying or conditioning the issuance or effectiveness of the policy or increasing the premium for an employer based on the manifestation of a disease or disorder of an individual who is covered under the policy; or

(ii) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer).

(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 preexisting 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 subchapter 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, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1395w-21(e)(4) of this title or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, 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 1395mm of this title, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1395l(a)(1)(A) of this title, 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 1395w-21(e)(4) of this title 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, any eligible organization under a contract under section 1395mm of this title, any similar organization operating under demonstration project authority, any PACE provider under section 1395eee of this title, 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 1395w-21(e) of this title).

(vi) The individual, upon first becoming eligible for benefits under part A at age 65, en-

rolls in a Medicare+ Choice plan under part C or in a PACE program under section 1395eee of this title, 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)(I) Subject to subclause (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).

(II) If the medicare supplemental policy referred to in subparagraph (B)(v) was a medigap Rx policy (as defined in subsection (v)(6)(A)), a medicare supplemental policy described in this subparagraph is such policy in which the individual was most recently enrolled as modified under subsection (v)(2)(C)(i) or, at the election of the individual, a policy referred to in subsection (v)(3)(A)(i).

(iii) Only for purposes of an individual described in subparagraph (B)(vi) and subject to subsection (v)(1), 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 1320a-7a of this title (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 1320a-7a(a) of this title.

(t) Medicare select policies

(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 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the pre-

vious sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(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 subchapter and under that policy) are not allowable under section 1395y(a)(1) of this title. 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)⁵ of section 1395u(b) of this title shall apply to the entity.

(u) Additional rules relating to individuals enrolled in MSA plans and in 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 1395w-21 of this title 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.

(v) Rules relating to medigap policies that provide prescription drug coverage

(1) Prohibition on sale, issuance, and renewal of new policies that provide prescription drug coverage

(A) In general

Notwithstanding any other provision of law, on or after January 1, 2006, a medigap Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

(i) to an individual who is a part D enrollee (as defined in paragraph (6)(B)); or

(ii) except as provided in subparagraph (B), to an individual who is not a part D enrollee.

(B) Continuation permitted for non-part D enrollees

Subparagraph (A)(ii) shall not apply to the renewal of a medigap Rx policy that was issued before January 1, 2006.

(C) Construction

Nothing in this subsection shall be construed as preventing the offering on and after January 1, 2006, of “H”, “I”, and “J” policies described in paragraph (2)(D)(i) if the benefit packages are modified in accordance with paragraph (2)(C).

(2) Elimination of duplicative coverage upon part D enrollment**(A) In general**

In the case of an individual who is covered under a medigap Rx policy and enrolls under a part D plan—

(i) before the end of the initial part D enrollment period, the individual may—

(I) enroll in a medicare supplemental policy without prescription drug coverage under paragraph (3); or

(II) continue the policy in effect subject to the modification described in subparagraph (C)(i); or

(ii) after the end of such period, the individual may continue the policy in effect subject to such modification.

(B) Notice required to be provided to current policyholders with medigap Rx policy

No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice (in accordance with standards of the Secretary established in consultation with the National Association of Insurance Commissioners) during the 60-day period immediately preceding the initial part D enrollment period, to each individual who is a policyholder or certificate holder of a medigap Rx policy (at the most recent available address of that individual) of the following:

(i) If the individual enrolls in a plan under part D during the initial enrollment period under section 1395w-101(b)(2)(A) of this title, the individual has the option of—

(I) continuing enrollment in the individual’s current plan, but the plan’s coverage of prescription drugs will be modified under subparagraph (C)(i); or

(II) enrolling in another medicare supplemental policy pursuant to paragraph (3).

(ii) If the individual does not enroll in a plan under part D during such period, the individual may continue enrollment in the individual’s current plan without change, but—

(I) the individual will not be guaranteed the option of enrollment in another medicare supplemental policy pursuant to paragraph (3); and

(II) if the current plan does not provide creditable prescription drug coverage (as

defined in section 1395w-113(b)(4) of this title), notice of such fact and that there are limitations on the periods in a year in which the individual may enroll under a part D plan and any such enrollment is subject to a late enrollment penalty.

(iii) Such other information as the Secretary may specify (in consultation with the National Association of Insurance Commissioners), including the potential impact of such election on premiums for medicare supplemental policies.

(C) Modification**(i) In general**

The policy modification described in this subparagraph is the elimination of prescription coverage for expenses of prescription drugs incurred after the effective date of the individual’s coverage under a part D plan and the appropriate adjustment of premiums to reflect such elimination of coverage.

(ii) Continuation of renewability and application of modification

No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

(I) continues renewability of medigap Rx policies that it has issued, subject to subclause (II); and

(II) applies the policy modification described in clause (i) in the cases described in clauses (i)(II) and (ii) of subparagraph (A).

(D) References to Rx policies**(i) H, I, and J policies**

Any reference to a benefit package classified as “H”, “I”, or “J” (including the benefit package classified as “J” with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2) shall be construed as including a reference to such a package as modified under subparagraph (C) and such packages as modified shall not be counted as a separate benefit package under such subsection.

(ii) Application in waived States

Except for the modification provided under subparagraph (C), the waivers previously in effect under subsection (p)(2) shall continue in effect.

(3) Availability of substitute policies with guaranteed issue**(A) In general**

The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as “A”, “B”, “C”, or “F” (including the benefit package classified as “F” with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), or a benefit package described in

subparagraph (A) or (B) of subsection (w)(2) and 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 not later than 63 days after the effective date of the individual's coverage under a part D plan.

(B) Individual covered

An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

(i) enrolls in a part D plan during the initial part D enrollment period;

(ii) at the time of such enrollment was enrolled in a medigap Rx policy issued by such issuer; and

(iii) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A).

(C) Special rule for waived States

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 subparagraph (A)(i), the references to benefit packages in such subparagraph are deemed references to comparable benefit packages offered in such State.

(4) Enforcement

(A) Penalties for duplication

The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of paragraph (1)(A).

(B) Guaranteed issue

The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of paragraph (3) in the same manner as they apply to the requirements of such subsection.

(5) Construction

Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met with respect to a part D enrollee through the continuation of the policy subject to modification under paragraph (2)(C) or the offering of a substitute policy under paragraph (3). The previous sentence shall not be construed to affect the guaranteed renewability of such a modified or substitute policy.

(6) Definitions

For purposes of this subsection:

(A) Medigap Rx policy

The term “medigap Rx policy” means a medicare supplemental policy—

(i) which has a benefit package classified as “H”, “I”, or “J” (including the benefit package classified as “J” with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2), without regard to this subsection; and

(ii) to which such standards do not apply (or to which such standards have been waived under subsection (p)(6)) but which provides benefits for prescription drugs.

Such term does not include a policy with a benefit package as classified under clause (i) which has been modified under paragraph (2)(C)(i).

(B) Part D enrollee

The term “part D enrollee” means an individual who is enrolled in a part D plan.

(C) Part D plan

The term “part D plan” means a prescription drug plan or an MA–PD plan (as defined for purposes of part D).

(D) Initial part D enrollment period

The term “initial part D enrollment period” means the initial enrollment period described in section 1395w–101(b)(2)(A) of this title.

(w) Development of new standards for medicare supplemental policies

(1) In general

The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the “1991 NAIC Model Regulation” deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to “date of enactment of this subsection” deemed a reference to December 8, 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

(2) New benefit packages

The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

(A) First new benefit package

A benefit package consisting of the following:

(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise ap-

plicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

(iii) A limitation on annual out-of-pocket expenditures under parts A and B to \$4,000 in 2006 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

(B) Second new benefit package

A benefit package consisting of the benefit package described in subparagraph (A), except as follows:

(i) Substitute “75 percent” for “50 percent” in clause (i) of such subparagraph.

(ii) Substitute “\$2,000” for “\$4,000” in clause (iii) of such subparagraph.

(x) Limitations on genetic testing and information

(1) Genetic testing

(A) Limitation on requesting or requiring genetic testing

An issuer of a medicare supplemental policy shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) Rule of construction

Subparagraph (A) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(C) Rule of construction regarding payment

(i) In general

Nothing in subparagraph (A) shall be construed to preclude an issuer of a medicare supplemental policy from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of subchapter XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (s)(2)(E).

(ii) Limitation

For purposes of clause (i), an issuer of a medicare supplemental policy may request only the minimum amount of information necessary to accomplish the intended purpose.

(D) Research exception

Notwithstanding subparagraph (A), an issuer of a medicare supplemental policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(i) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(ii) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that—

(I) compliance with the request is voluntary; and

(II) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(iii) No genetic information collected or acquired under this subparagraph shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rating, or the creation, renewal, or replacement of a plan, contract, or coverage for health insurance or health benefits.

(iv) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subparagraph, including a description of the activities conducted.

(v) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subparagraph.

(2) Prohibition on collection of genetic information

(A) In general

An issuer of a medicare supplemental policy shall not request, require, or purchase genetic information for underwriting purposes (as defined in paragraph (3)).

(B) Prohibition on collection of genetic information prior to enrollment

An issuer of a medicare supplemental policy shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(C) Incidental collection

If an issuer of a medicare supplemental policy obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subparagraph (B) if such request, requirement, or purchase is not in violation of subparagraph (A).

(3) Definitions

In this subsection:

(A) Family member

The term “family member” means with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(B) Genetic information**(i) In general**

The term “genetic information” means, with respect to any individual, information about—

- (I) such individual’s genetic tests,
- (II) the genetic tests of family members of such individual, and
- (III) subject to clause (iv), the manifestation of a disease or disorder in family members of such individual.

(ii) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(iii) Exclusions

The term “genetic information” shall not include information about the sex or age of any individual.

(C) Genetic test**(i) In general**

The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(ii) Exceptions

The term “genetic test” does not mean—

- (I) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
- (II) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(D) Genetic services

The term “genetic services” means—

- (i) a genetic test;
- (ii) genetic counseling (including obtaining, interpreting, or assessing genetic information); or
- (iii) genetic education.

(E) Underwriting purposes

The term “underwriting purposes” means, with respect to a medicare supplemental policy—

- (i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
- (ii) the computation of premium or contribution amounts under the policy;
- (iii) the application of any pre-existing condition exclusion under the policy; and
- (iv) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(F) Issuer of a medicare supplemental policy

The term “issuer of a medicare supplemental policy” includes a third-party ad-

ministrators or other person acting for or on behalf of such issuer.

(4) Genetic information of a fetus or embryo

Any reference in this section to genetic information concerning an individual or family member of an individual shall—

(A) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(B) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(y) Development of new standards for certain medicare supplemental policies**(1) In general**

The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians’ services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the “1991 NAIC Model Regulation” deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to “date of enactment of this subsection” deemed a reference to March 23, 2010. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

(2) Benefit packages described

The benefit packages described in this paragraph are benefit packages classified as “C” and “F”.

(z) Limitation on certain medigap policies for newly eligible Medicare beneficiaries**(1) In general**

Notwithstanding any other provision of this section, on or after January 1, 2020, a medicare supplemental policy that provides coverage of the part B deductible, including any such policy (or rider to such a policy) issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible Medicare beneficiary.

(2) Newly eligible Medicare beneficiary defined

In this subsection, the term “newly eligible Medicare beneficiary” means an individual who is neither of the following:

(A) An individual who has attained age 65 before January 1, 2020.

(B) An individual who was entitled to benefits under part A pursuant to section 426(b)

or 426-1 of this title, or deemed to be eligible for benefits under section 426(a) of this title, before January 1, 2020.

(3) Treatment of waived States

In the case of a State described in subsection (p)(6), nothing in this section shall be construed as preventing the State from modifying its alternative simplification program under such subsection so as to eliminate the coverage of the part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible Medicare beneficiary on or after January 1, 2020.

(4) Treatment of references to certain policies

In the case of a newly eligible Medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a medicare supplemental policy which has a benefit package classified as “C” or “F” shall be deemed, as of January 1, 2020, to be a reference to a medicare supplemental policy which has a benefit package classified as “D” or “G”, respectively.

(5) Enforcement

The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.

(Aug. 14, 1935, ch. 531, title XVIII, § 1882, as added Pub. L. 96-265, title V, § 507(a), June 9, 1980, 94 Stat. 476; amended H. Res. 549, Mar. 25, 1980; Pub. L. 100-93, § 13, Aug. 18, 1987, 101 Stat. 697; Pub. L. 100-203, title IV, § 4081(b), Dec. 22, 1987, 101 Stat. 1330-127; Pub. L. 100-360, title II, § 221(a)-(f), title IV, §§ 411(i)(1)(B), (C), 428(b), July 1, 1988, 102 Stat. 742-746, 788, 817; Pub. L. 101-234, title II, § 203(a)(1), Dec. 13, 1989, 103 Stat. 1982; Pub. L. 101-508, title IV, §§ 4207(k)(1), formerly 4027(k)(1), 4351, formerly 4351(a), 4352, 4353(a)-(d)(1), 4354(a), (b), 4355(a)-(c), 4356(a), 4357(a), 4358(a), (b)(1), (2), Nov. 5, 1990, 104 Stat. 1388-124, 1388-125, 1388-129, 1388-130, 1388-132, 1388-134 to 1388-137; Pub. L. 103-432, title I, §§ 160(d)(4), 171(a)-(d)(3)(B), (4), (e)(1), (2), (f)(1), (g), (h)(1), (j)(2), (k), Oct. 31, 1994, 108 Stat. 4444-4451; Pub. L. 104-191, title II, § 271(a), (b), Aug. 21, 1996, 110 Stat. 2034-2036; Pub. L. 105-33, title IV, §§ 4002(j)(2), 4003, 4031(a)-(c), 4032(a), Aug. 5, 1997, 111 Stat. 330, 355, 357, 359; Pub. L. 105-362, title VI, § 601(b)(6), Nov. 10, 1998, 112 Stat. 3286; Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 321(k)(13), (14), title V, §§ 501(a)(2), 536(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-368, 1501A-378, 1501A-390; Pub. L. 106-170, title II, § 205(a), Dec. 17, 1999, 113 Stat. 1899; Pub. L. 106-554, § 1(a)(6) [title VI, § 618], Dec. 21, 2000, 114 Stat. 2763, 2763A-562; Pub. L. 108-173, title I, § 104(a), (b), title VII, § 736(e), Dec. 8, 2003, 117 Stat. 2161, 2164, 2357; Pub. L. 110-161, div. H, title I, § 1502(f), Dec. 26, 2007, 121 Stat. 2250; Pub. L. 110-233, title I, § 104(a), (b), May 21, 2008, 122 Stat. 899, 900; Pub. L. 110-275, title I, § 104(b), July 15, 2008, 122 Stat. 2502; Pub. L. 111-148, title III, § 3210, Mar. 23, 2010, 124 Stat. 460; Pub. L. 114-10, title IV, § 401, Apr. 16, 2015, 129 Stat. 159.)

Editorial Notes

REFERENCES IN TEXT

Section 171(m) of the Social Security Act Amendments of 1994, referred to in subsecs. (d)(3)(A)(vi)(IV) and (r)(1), (2)(A), is section 171(m) of Pub. L. 103-432, title I, Oct. 31, 1994, 108 Stat. 4452, which is set out as a note below.

Section 603(c) of the Social Security Amendments of 1983, referred to in subsec. (g)(1), is section 603(c) of Pub. L. 98-21, title VI, Apr. 20, 1983, 97 Stat. 168, which was not classified to the Code, and was repealed by Pub. L. 105-33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

Section 2355 of the Deficit Reduction Act of 1984, referred to in subsec. (g)(1), is section 2355 of Pub. L. 98-369, div. B, title III, July 18, 1984, 98 Stat. 1103, which is not classified to the Code.

Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, referred to in subsec. (g)(1), is section 9412(b) of Pub. L. 99-509, title IX, Oct. 21, 1986, 100 Stat. 2062, which was not classified to the Code, and was repealed by Pub. L. 105-33, title IV, § 4803(d), Aug. 5, 1997, 111 Stat. 550, subject to transition provisions.

The Medicare Catastrophic Coverage Act of 1988, referred to in subsecs. (k)(1)(A), (2)(A) and (l)(4)(A), is Pub. L. 100-360, July 1, 1988, 102 Stat. 683. For complete classification of this Act to the Code, see Short Title of 1988 Amendment note set out under section 1305 of this title and Tables.

The Medicare Catastrophic Coverage Repeal Act of 1989, referred to in subsecs. (m)(1)(A), (2)(A) and (n)(2)(A), (5)(A), is Pub. L. 101-234, Dec. 13, 1989, 103 Stat. 1979. For complete classification of this Act to the Code, see Short Title of 1989 Amendment note set out under section 1305 of this title and Tables.

The Omnibus Budget Reconciliation Act of 1990, referred to in subsec. (p)(1)(A)(iv), is Pub. L. 101-508, Nov. 5, 1990, 104 Stat. 1388. For complete classification of this Act to the Code, see Tables.

Section 2701 of the Public Health Service Act, referred to in subsec. (s)(2)(D), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Paragraphs (2)(A), (B) and (3)(C)-(E) of section 1395u(b) of this title, referred to in subsec. (t)(3), were repealed by Pub. L. 108-173, title IX, § 911(c)(3)(B)(i), (C)(iv), Dec. 8, 2003, 117 Stat. 2384.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to in subsec. (w)(1), is Pub. L. 108-173, Dec. 8, 2003, 117 Stat. 2066. For complete classification of this Act to the Code, see Short Title of 2003 Amendment note set out under section 1305 of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (x)(1)(C)(i), is section 264 of Pub. L. 104-191, which is set out as a note under section 1320d-2 of this title.

AMENDMENTS

2015—Subsec. (z). Pub. L. 114-10 added subsec. (z).

2010—Subsec. (o)(1). Pub. L. 111-148, § 3210(b), substituted “(w), and (y)” for “, and (w)”.

Subsec. (y). Pub. L. 111-148, § 3210(a), added subsec. (y).

2008—Subsec. (o)(4). Pub. L. 110-233, § 104(b)(3), added par. (4).

Subsec. (o)(5). Pub. L. 110-275 added par. (5).

Subsec. (s)(2)(E), (F). Pub. L. 110-233, §104(a), added subpars. (E) and (F).

Subsec. (x). Pub. L. 110-233, §104(b)(1), added subsec. (x).

Subsec. (x)(4). Pub. L. 110-233, §104(b)(2), added par. (4).

2007—Subsec. (r)(5). Pub. L. 110-161 substituted “The Secretary may” for “(A) The Comptroller General shall periodically, not less often than once every 3 years,” and struck out “and to the Secretary” after “State involved” and subpar. (B) which read as follows: “The Secretary may independently perform such compliance audits.”

2003—Subsec. (d)(3)(A)(i)(II). Pub. L. 108-173, § 736(e)(1), substituted “plan, a medicare supplemental policy” for “plan a medicare supplemental policy”.

Subsec. (d)(3)(B)(iii)(II). Pub. L. 108-173, § 736(e)(2), substituted “to the best of the issuer’s or seller’s knowledge” for “to the best of the issuer or seller’s knowledge”.

Subsec. (g)(1). Pub. L. 108-173, §104(b)(2)(A), inserted “a prescription drug plan under part D or” after “but does not include”.

Subsec. (g)(2)(A). Pub. L. 108-173, § 736(e)(3), substituted “medicare supplemental policies” for “medicare supplement policies”.

Subsec. (o)(1). Pub. L. 108-173, §104(b)(2)(B), substituted “subsections (p), (v), and (w)” for “subsection (p)”.

Subsec. (p)(2)(B). Pub. L. 108-173, § 736(e)(4), substituted “; and” for “, and” at end.

Subsec. (s)(3)(A)(iii). Pub. L. 108-173, § 736(e)(5), substituted “pre-existing” for “pre-existing”.

Subsec. (s)(3)(C)(ii). Pub. L. 108-173, §104(a)(2)(A), designated existing provisions as subcl. (I), substituted “Subject to subclause (II), only” for “Only”, and added subcl. (II).

Subsec. (s)(3)(C)(iii). Pub. L. 108-173, §104(a)(2)(B), inserted “and subject to subsection (v)(1)” after “subparagraph (B)(vi)”.

Subsec. (v). Pub. L. 108-173, §104(a)(1), added subsec. (v).

Subsec. (w). Pub. L. 108-173, §104(b)(1), added subsec. (w).

2000—Subsec. (s)(3)(A). Pub. L. 106-554, §1(a)(6) [title VI, §618(a)(1)], in concluding provisions, 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”.

Subsec. (s)(3)(E). Pub. L. 106-554, §1(a)(6) [title VI, §618(a)(2)], added subpar. (E) and struck out former subpar. (E) which read as follows:

“(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.”

Subsec. (s)(3)(F). Pub. L. 106-554, §1(a)(6) [title VI, §618(b)], added subpar. (F).

1999—Subsec. (g)(1). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(13)], struck out “or” after “; but does not include”.

Subsec. (q)(5)(C). Pub. L. 106-170, § 205(a)(1), inserted “or paragraph (6)” after “this paragraph”.

Subsec. (q)(6). Pub. L. 106-170, § 205(a)(2), added par. (6).

Subsec. (s)(2)(D). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(14)], inserted “section” after “(as defined in” in introductory provisions.

Subsec. (s)(3)(A). Pub. L. 106-113, §1000(a)(6) [title V, §501(a)(2)(A)], inserted “, subject to subparagraph (E),” after “in the case of an individual described in subparagraph (B) who” in concluding provisions.

Subsec. (s)(3)(B)(ii). Pub. L. 106-113, §1000(a)(6) [title V, §536(a)(1)], inserted before period at end “or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1395eee of this title, 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”.

Subsec. (s)(3)(B)(v)(II). Pub. L. 106-113, §1000(a)(6) [title V, §536(a)(2)], inserted “any PACE provider under section 1395eee of this title,” after “demonstration project authority.”

Subsec. (s)(3)(B)(vi). Pub. L. 106-113, §1000(a)(6) [title V, §536(a)(3)], inserted “or in a PACE program under section 1395eee of this title” after “part C” and substituted “such plan or such program” for “such plan”.

Subsec. (s)(3)(E). Pub. L. 106-113, §1000(a)(6) [title V, §501(a)(2)(B)], added subpar. (E).

1998—Subsec. (I)(6). Pub. L. 105-362 struck out par. (6) which read as follows: “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).”

1997—Subsec. (d)(3)(A)(i). Pub. L. 105-33, § 4003(a)(1)(A), inserted “(including an individual electing a Medicare+Choice plan under section 1395w-21 of this title)” after “part B of this subchapter” in introductory provisions.

Subsec. (d)(3)(A)(i)(II). Pub. L. 105-33, § 4003(a)(1)(B), inserted “in the case of an individual not electing a Medicare+Choice plan” after “(II)” and inserted “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” before comma at end.

Subsec. (d)(3)(A)(vi)(III). Pub. L. 105-33, § 4031(c), inserted “, a policy described in clause (v),” after “Medicare supplemental policy”.

Subsec. (d)(3)(B)(i)(D). Pub. L. 105-33, § 4003(a)(2), inserted “(including any Medicare+Choice plan)” after “health insurance policies”.

Subsec. (g)(1). Pub. L. 105-33, § 4003(a)(3), inserted “or a Medicare+Choice plan or” after “does not include” the first place appearing.

Pub. L. 105-33, §4002(j)(2), struck out “, during the period beginning on the date specified in subsection (p)(1)(C) of this section and ending on December 31, 1995,” after “Omnibus Budget Reconciliation Act of 1986, or”.

Subsec. (p)(2)(C). Pub. L. 105-33, § 4032(a)(1), inserted before period at end “plus the 2 plans described in paragraph (11)(A)”.

Subsec. (p)(11). Pub. L. 105-33, § 4032(a)(2), added par. (11).

Subsec. (s)(2)(B). Pub. L. 105-33, § 4031(b)(1), substituted “subparagraphs (C) and (D)” for “subparagraph (C)”.

Subsec. (s)(2)(D). Pub. L. 105-33, § 4031(b)(2), added subpar. (D).

Subsec. (s)(3). Pub. L. 105-33, § 4031(a)(3), added par. (3). Former par. (3) redesignated (4).

Pub. L. 105-33, §4031(a)(1), (2), substituted “requirements of this subsection” for “requirements of paragraphs (1) and (2)” and redesignated par. (3) as (4).

Subsec. (s)(4). Pub. L. 105-33, § 4031(a)(2), redesignated par. (3) as (4).

Subsec. (u). Pub. L. 105-33, § 4003(b), added subsec. (u).

1996—Subsec. (d)(3)(A)(iii). Pub. L. 104-191, §271(a)(1), substituted “clause (i)(II)” for “clause (i)”.

Subsec. (d)(3)(A)(iv) to (viii). Pub. L. 104-191, §271(a)(2), added cls. (iv) to (viii).

Subsec. (d)(3)(C). Pub. L. 104-191, §271(b)(1), substituted “with respect to” for “with respect to (i)” and struck out before period at end “, (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 subchapter XIX of this chapter) 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 subchapter, 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”.

Subsec. (d)(3)(D). Pub. L. 104-191, §271(b)(2), struck out subpar. (D) which provided for development of statements for various types of health insurance policies sold or issued to persons entitled to health benefits under this subchapter regarding extent to which benefits payable under those policies duplicate benefits under this subchapter.

1994—Subsec. (a)(2). Pub. L. 103-432, §171(c)(1)(B), in closing provisions 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”.

Subsec. (a)(2)(A). Pub. L. 103-432, §171(c)(1)(A), substituted “1991 NAIC Model Regulation or 1991 Federal Regulation” for “NAIC standards or the Federal standards”.

Subsec. (b)(1). Pub. L. 103-432, §171(e)(2), substituted “subparagraph (F)” for “subsection (F)” in last sentence.

Pub. L. 103-432, §171(c)(4), substituted “the Secretary determines” for “the the Secretary determines” in introductory provisions.

Pub. L. 103-432, §171(c)(2), in last sentence substituted “Each report” for “The report”, “fail to meet the standards and requirements” for “fail to meet the standards”, “compliance, information regarding” for “compliance, and information regarding”, and “Commissioners may specify” for “Commissioners, may specify”.

Subsecs. (b)(1)(B), (c)(5). Pub. L. 103-432, §171(a)(1), made technical amendment to Pub. L. 101-508, §4351. See 1990 Amendment notes below.

Subsec. (d)(3)(A). Pub. L. 103-432, §171(d)(1)(D), struck out at end “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) of this section.”

Pub. L. 103-432, §171(d)(1)(C), designated third sentence as cl. (iii), substituted “clause (i) with respect to the sale of a medicare supplemental policy” for “the previous sentence”, and struck out “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” after “compliance with subparagraph (B)”.

Pub. L. 103-432, §171(d)(1)(B), designated second sentence as cl. (ii) and substituted “Whoever violates clause (i)” for “Whoever violates the previous sentence”.

Pub. L. 103-432, §171(d)(1)(A), designated first sentence as cl. (i) and amended it generally. Prior to amendment, first sentence read as follows: “It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, 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 subchapter or subchapter XIX of this chapter).”

Subsec. (d)(3)(B)(ii)(II). Pub. L. 103-432, §171(d)(2)(A), struck out “65 years of age or older” before “may be eligible”.

Subsec. (d)(3)(B)(iii)(I). Pub. L. 103-432, §171(d)(2)(B), (C), substituted “has a medicare supplemental policy” for “has another medicare supplemental policy” and “sale of a medicare supplemental policy” for “sale of such a policy”.

Subsec. (d)(3)(B)(iii)(II). Pub. L. 103-432, §171(d)(2)(D), substituted “has a medicare supplemental policy” for “has another policy”.

Subsec. (d)(3)(B)(iii)(III). Pub. L. 103-432, §171(d)(2)(E), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: “Subclause (I) also shall not apply if a State medicaid plan under subchapter XIX of this chapter pays the premiums for the policy, or pays less than an individual’s (who is described in section 1396d(p)(1) of this title) full liability for medicare cost sharing as defined in section 1396d(p)(3)(A) of this title.”

Subsec. (d)(3)(C). Pub. L. 103-432, §171(d)(3)(A), substituted “(i) the sale or issuance of a group policy” for “the selling of a group policy” and added cls. (ii) and (iii).

Subsec. (d)(3)(D). Pub. L. 103-432, §171(d)(3)(B), added subpar. (D).

Subsec. (d)(4)(D). Pub. L. 103-432, §171(k)(1), struck out before period at end “, if such policy expires not more than 12 months after the date on which the duplicate copy is mailed”.

Subsec. (d)(4)(E). Pub. L. 103-432, §171(k)(2), added subpar. (E).

Subsec. (f)(3). Pub. L. 103-432, §171(j)(2), added par. (3).

Subsec. (g)(1). Pub. L. 103-432, §171(f)(1), substituted “an eligible organization (as defined in section 1395mm(b) of this title) if the policy or plan provides benefits pursuant to a contract under section 1395mm of this title 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) of this section 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 1395f(a)(1)(A) of this title” for “a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under section 1395mm of this title or an agreement under section 1395f of this title.”

Subsec. (g)(2)(B). Pub. L. 103-432, §171(c)(3), substituted “Secretary” for “Panel”.

Subsec. (o). Pub. L. 103-432, §171(a)(1), made technical amendment to Pub. L. 101-508, §4351. See 1990 Amendment note below.

Subsec. (p). Pub. L. 103-432, §171(a)(1), made technical amendment to Pub. L. 101-508, §4351. See 1990 Amendment note below.

Subsec. (p)(1)(A). Pub. L. 103-432, §171(a)(2)(A), in introductory provisions, substituted “changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate” for “promulgates”, and in closing provisions, struck out “(such limitations, language, definitions, format, and standards referred to collectively in this subsection as ‘NAIC standards’),” before “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”.

Subsec. (p)(1)(B). Pub. L. 103-432, §171(a)(2)(B), substituted “make the changes in the revised NAIC Model Regulation” for “promulgate NAIC standards”, “a reg-

ulation” 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 “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”.

Subsec. (p)(1)(C)(i). Pub. L. 103-432, §171(a)(2)(C), substituted “1991 NAIC Model Regulation or 1991 Federal Regulation” for “NAIC standards or the Federal standards”.

Subsec. (p)(1)(C)(ii)(I), (E). Pub. L. 103-432, §171(a)(2)(D), substituted “1991 NAIC Model Regulation or 1991 Federal Regulation” for “NAIC or Federal standards”.

Subsec. (p)(2). Pub. L. 103-432, §171(a)(2)(D), substituted “1991 NAIC Model Regulation or 1991 Federal Regulation” for “NAIC or Federal standards” in introductory provisions.

Subsec. (p)(2)(C). Pub. L. 103-432, §171(a)(2)(E), substituted “paragraph (4)(B)” for “paragraph (5)(B)”.

Subsec. (p)(4). Pub. L. 103-432, §171(a)(2)(G), substituted “applicable 1991 NAIC Model Regulation or 1991 Federal Regulation” for “applicable standards” wherever appearing.

Subsec. (p)(4)(A)(i). Pub. L. 103-432, §171(a)(2)(F), inserted “or paragraph (6)” after “subparagraph (B)”.

Subsec. (p)(6). Pub. L. 103-432, §171(a)(2)(H), substituted “described in clauses (i) through (iii) of paragraph (1)(A)” for “in regard to the limitation of benefits described in paragraph (4)”.

Subsec. (p)(7). Pub. L. 103-432, §171(a)(2)(I), substituted “policyholders” for “policyholder”.

Subsec. (p)(8). Pub. L. 103-432, §171(a)(2)(J), 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”.

Subsec. (p)(9)(B). Pub. L. 103-432, §171(a)(2)(D), substituted “1991 NAIC Model Regulation or 1991 Federal Regulation” for “NAIC or Federal standards”.

Subsec. (p)(9)(D). Pub. L. 103-432, §171(a)(2)(K), added subpar. (D).

Subsec. (p)(10). Pub. L. 103-432, §171(a)(2)(L), substituted “consistent with paragraph (1)(A)(i)” for “consistent with this subsection”.

Subsec. (q)(2). Pub. L. 103-432, §171(b)(1), substituted “paragraph (4)” for “paragraph (2)”.

Subsec. (q)(4). Pub. L. 103-432, §171(b)(2), substituted “issuer of the replacement policy” for “the succeeding issuer”.

Subsec. (q)(5)(A), (B). Pub. L. 103-432, §171(d)(4), made technical amendment to the reference to subchapter XIX of this chapter to correct reference to corresponding provision of original act.

Subsec. (r)(1). Pub. L. 103-432, §171(e)(1)(A), (E), in introductory provisions substituted “or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))” for “or sold” and inserted at end of closing provisions “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.”

Subsec. (r)(1)(A). Pub. L. 103-432, §171(e)(1)(C), substituted “Commissioners” for “Commissioners.”.

Pub. L. 103-432, §171(e)(1)(B), inserted “for periods after the effective date of these provisions” after “the policy can be expected”.

Subsec. (r)(1)(B). Pub. L. 103-432, §171(e)(1)(D), inserted before period at end “, treating policies of the same type as a single policy for each standard package”.

Subsec. (r)(2)(A). Pub. L. 103-432, §171(e)(1)(F)–(I), substituted “by standard package” for “by policy number” in first sentence and “until 12 months following issue” for “with respect to the first 2 years in which it is in effect” in second sentence, struck out “in order to apply paragraph (1)(B) to the first 2 years in which policies are effective” after “may be appropriate” in third sentence, and inserted at end “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.”

Subsec. (r)(2)(C), (D). Pub. L. 103-432, §171(e)(1)(J), substituted “calendar year” for “policy year” wherever appearing.

Subsec. (r)(4). Pub. L. 103-432, §171(e)(1)(K), substituted “October” for “February”, “disallowance” for “disallowance”, “loss ratios” for “loss-ratios” in two places, and “loss ratio” for “loss-ratio”.

Subsec. (r)(6)(A). Pub. L. 103-432, §171(e)(1)(L), 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 “policy issued for which such failure occurred” for “such violation”.

Subsec. (r)(6)(B). Pub. L. 103-432, §171(e)(1)(M), substituted “to the policyholder or, in the case of a group policy, to the certificate holder” for “to policyholders”.

Subsec. (s)(2)(A). Pub. L. 103-432, §171(g)(1), (2), substituted “in the case of an individual for whom an application is submitted prior to or” for “for which an application is submitted” and “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”.

Subsec. (s)(2)(B). Pub. L. 103-432, §171(g)(3), substituted “before the policy became effective” for “before it became effective”.

Subsec. (t)(1). Pub. L. 103-432, §171(h)(1)(A), (B), substituted “If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation” for “If a policy meets the NAIC Model Standards”.

Subsec. (t)(1)(A). Pub. L. 103-432, §171(h)(1)(C), inserted “or agreements” after “contracts”.

Subsec. (t)(1)(E)(i), (F). Pub. L. 103-432, §171(h)(1)(D), substituted “standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation” for “NAIC standards”.

Subsec. (t)(2). Pub. L. 103-432, §171(h)(1)(E), inserted “the issuer” before “is subject to a civil money penalty” in concluding provisions.

1990—Pub. L. 101-508, §4353(a)(1), struck out “Voluntary” at beginning of section catchline.

Subsec. (a). Pub. L. 101-508, §4353(a)(2), designated existing provisions as par. (1) and added par. (2).

Pub. L. 101-508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103-432, §160(d)(4), struck out “(k)(4),” after “subsections (k)(3),” in third sentence.

Subsec. (b)(1). Pub. L. 101-508, §4353(c)(5), inserted at end “The report required under subsection (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 of this paragraph, actions taken by the State to bring such policies into compliance, and 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.”

Pub. L. 101-508, §4353(b)(1), (2), substituted “the Secretary” for “Supplemental Health Insurance Panel (established under paragraph (2))” in introductory provisions and for “the Panel” in concluding provisions.

Pub. L. 101-508, §4207(k)(1), formerly §4027(k)(1), as renumbered by Pub. L. 103-432, §160(d)(4), which directed

the amendment of third sentence of par. (1) by striking out “(k)(4),” was executed by making the deletion after “subsections (k)(3),” in concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(1)(A). Pub. L. 101-508, § 4358(b)(2)(A), inserted before semicolon at end “, except as otherwise provided by subparagraph (H)”.

Pub. L. 101-508, § 4353(b)(3), inserted “and enforcement” after “application”.

Subsec. (b)(1)(B). Pub. L. 101-508, § 4351(1), formerly § 4351(a)(1), as renumbered and amended by Pub. L. 103-432, § 171(a)(1), substituted “through (5)” for “through (4)”.

Subsec. (b)(1)(C). Pub. L. 101-508, § 4355(b), substituted for semicolon at end “, 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;”.

Subsec. (b)(1)(D). Pub. L. 101-508, § 4353(b)(3), inserted “and enforcement” after “application”.

Subsec. (b)(1)(F). Pub. L. 101-508, § 4353(c)(1)-(3), added subpar. (F).

Subsec. (b)(1)(G). Pub. L. 101-508, § 4355(c), which directed amendment of par. (1) by adding at the end thereof a new subpar. (G), was executed by adding the new subpar. (G) immediately after subpar. (F) to reflect the probable intent of Congress.

Subsec. (b)(1)(H). Pub. L. 101-508, § 4358(b)(2)(B)-(D), added subpar. (H).

Subsec. (b)(2). Pub. L. 101-508, § 4353(b)(4), amended par. (2) generally. Prior to amendment, par. (2) read as follows:

“(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.”

Subsec. (c). Pub. L. 101-508, § 4357(a)(1), inserted “or the requirement described in subsection (s)” after “paragraph (3)” in introductory provisions.

Pub. L. 101-508, § 4355(a)(2), struck out at end “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.”

Subsec. (c)(1). Pub. L. 101-508, § 4358(b)(1), inserted before semicolon at end “(except as otherwise provided by subsection (t))”.

Subsec. (c)(2). Pub. L. 101-508, § 4355(a)(1), amended par. (2) generally. Prior to amendment, par. (2) read as follows: “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;”.

Subsec. (c)(5). Pub. L. 101-508, § 4351(2), formerly § 4351(a)(2), as renumbered and amended by Pub. L. 103-432, § 171(a)(1), added par. (5).

Subsec. (d)(3)(A). Pub. L. 101-508, § 4354(a)(1), substituted “It is unlawful for a person to sell or issue” for “Whoever knowingly sells”, “duplicates health benefits” for “substantially duplicates health benefits”, “Whoever violates the previous sentence shall be fined” for “, shall be fined”, “(other than this subchapter or subchapter XIX of this chapter)” for “(other than this subchapter)”, and “\$25,000 (or \$15,000 in the case of a person other than the issuer of the policy)” for “\$5,000” and inserted at end “A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the policy is sold in compliance with subparagraph (B) 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) of this section.”

Subsec. (d)(3)(B). Pub. L. 101-508, § 4354(a)(2), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “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.”

Subsec. (d)(4)(B). Pub. L. 101-508, § 4353(d)(1), struck out at end “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) of this section or was issued in a State with an approved regulatory program (as defined in subsection (g)(2)(B) of this section);

“(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.”

Subsec. (g)(1). Pub. L. 101-508, § 4356(a), inserted before period at end of first sentence “and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under under section 1395mm of this title or an agreement under section 1395l of this title”.

Subsecs. (o), (p). Pub. L. 101-508, § 4351(3), formerly § 4351(a)(3), as renumbered and amended by Pub. L. 103-432, § 171(a)(1), added subsecs. (o) and (p).

Subsec. (q). Pub. L. 101-508, § 4352, added subsec. (q).

Subsec. (q)(5). Pub. L. 101-508, § 4354(b), added par. (5).

Subsec. (r). Pub. L. 101-508, § 4355(a)(3), added subsec. (r).

Subsec. (s). Pub. L. 101-508, § 4357(a)(2), added subsec. (s).

Subsec. (t). Pub. L. 101-508, § 4358(a), added subsec. (t). 1989—Subsecs. (a), (b)(1). Pub. L. 101-234, § 203(a)(1)(A), substituted “subsections (k)(3), (k)(4), (m), and (n)” for “subsection (k)(3)”.

Subsec. (k)(1)(A). Pub. L. 101-234, § 203(a)(1)(B)(i), inserted “except as provided in subsection (m),” before “subsection (g)(2)(A)”.

Subsec. (k)(3). Pub. L. 101-234, § 203(a)(1)(B)(ii), substituted “subsections (l), (m), and (n)” for “subsection (l)”.

Subsecs. (m), (n). Pub. L. 101-234, § 203(a)(1)(C), added subsecs. (m) and (n).

1988—Subsec. (a). Pub. L. 100-360, § 221(d)(1), substituted “Subject to subsection (k)(3), such” for “Such”.

Subsec. (b)(1). Pub. L. 100-360, § 221(d)(2), substituted “(subject to subsection (k)(3), for so long as” for “(for so long as” in concluding provisions.

Subsec. (b)(1)(B). Pub. L. 100-360, § 221(a)(1), substituted “through (4)” for “and (3)”.

Subsec. (b)(1)(C). Pub. L. 100-360, § 221(b)(2), (3), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 100-360, § 221(b)(1), substituted “(A), (B), and (C)” for “(A) and (B)”.

Subsec. (b)(1)(D), (E). Pub. L. 100-360, § 221(b)(2), redesignated former subpars. (C) and (D) as (D) and (E), respectively.

Subsec. (b)(2)(A). Pub. L. 100-360, § 221(f), substituted “appointed by the Secretary” for “appointed by the President”.

Subsec. (b)(3). Pub. L. 100-360, § 221(e), added par. (3).

Subsec. (c). Pub. L. 100-360, § 411(i)(1)(B), added Pub. L. 100-203, § 4081(b)(2)(A), see 1987 Amendment note below.

Subsec. (c)(3). Pub. L. 100-360, § 411(i)(1)(B), redesignated Pub. L. 100-203, § 4081(b)(2)(B)–(D), see 1987 Amendment note below.

Subsec. (c)(3)(A). Pub. L. 100-360, § 411(i)(1)(C)(i), substituted “claim form” for “claims form” in two places and “such notice” for “such claims form”.

Subsec. (c)(3)(B)(i). Pub. L. 100-360, § 411(i)(1)(C)(ii), inserted “under the policy” after “payment determination”.

Subsec. (c)(3)(B)(ii). Pub. L. 100-360, § 411(i)(1)(C)(iii), substituted “payment covered by such policy” for “appropriate payment”.

Subsec. (c)(4). Pub. L. 100-360, § 221(a)(2), added par. (4).

Subsec. (d). Pub. L. 100-360, § 428(b)(1), substituted “shall be fined under title 18 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” in pars. (1), (2), (3)(A), and (4)(A).

Subsec. (d)(5). Pub. L. 100-360, § 428(b)(2), added par. (5).

Subsec. (e). Pub. L. 100-360, § 221(c), designated existing provision as par. (1) and added pars. (2) and (3).

Subsecs. (k), (l). Pub. L. 100-360, § 221(d)(3), added subsecs. (k) and (l).

1987—Subsec. (b)(1)(B). Pub. L. 100-203, § 4081(b)(1)(A), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: “includes a requirement equal to or more stringent than the requirement described in subsection (c)(2) of this section; and”.

Subsec. (b)(1)(D). Pub. L. 100-203, § 4081(b)(1)(B), (C), added subpar. (D).

Subsec. (c). Pub. L. 100-203, § 4081(b)(2)(A), as added by Pub. L. 100-360, § 411(i)(1)(B), inserted “(or, with respect to paragraph (3), the issuer of the policy)” in introductory provisions.

Subsec. (c)(3). Pub. L. 100-203, § 4081(b)(2)(B)–(D), formerly § 4081(b)(2), as redesignated by Pub. L. 100-360, § 411(i)(1)(B), added par. (3).

Subsec. (d)(1). Pub. L. 100-93 substituted “knowingly and willfully” for “knowingly or willfully”.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and

Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

Committee on Interstate and Foreign Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives immediately prior to noon on Jan. 3, 1981, by House Resolution No. 549, Ninety-sixth Congress, Mar. 25, 1980. Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104-14, set out as a note preceding section 21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-233, title I, § 104(c), May 21, 2008, 122 Stat. 903, provided that: “The amendments made by this section [amending this section] shall apply with respect to an issuer of a medicare supplemental policy for policy years beginning on or after the date that is 1 year after the date of enactment of this Act [May 21, 2008].”

EFFECTIVE DATE OF 1999 AMENDMENTS

Pub. L. 106-170, title II, § 205(b), Dec. 17, 1999, 113 Stat. 1900, provided that: “The amendments made by subsection (a) [amending this section] apply with respect to requests made after the date of the enactment of this Act [Dec. 17, 1999].”

Amendment by section 1000(a)(6) [title III, § 321(k)(13), (14)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Amendment by section 1000(a)(6) [title V, § 501(a)(2)] of Pub. L. 106-113 applicable to notices of impending terminations or discontinuances made on or after Nov. 29, 1999, see section 1000(a)(6) [title V, § 501(d)(1)] of Pub. L. 106-113, set out as a note under section 1395w-21 of this title.

Pub. L. 106-113, div. B, § 1000(a)(6) [title V, § 536(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-391, provided that: “The amendments made by this section [amending this section] shall apply to terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999].”

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-33, title IV, § 4002(j)(2), Aug. 5, 1997, 111 Stat. 330, provided that the amendment made by that section is effective Jan. 1, 1999.

Pub. L. 105-33, title IV, § 4031(d), Aug. 5, 1997, 111 Stat. 357, provided that:

“(1) **GUARANTEED ISSUE.**—The amendment made by subsection (a) [amending this section] shall take effect on July 1, 1998.

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

“(3) **CONFORMING AMENDMENT.**—The amendment made by subsection (c) [amending this section] shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].”

Pub. L. 105-33, title IV, § 4032(b), Aug. 5, 1997, 111 Stat. 359, provided that:

“(1) **IN GENERAL.**—The amendments made by subsection (a) [amending this section] shall take effect the date of the enactment of this Act [Aug. 5, 1997].

“(2) **TRANSITION.**—The provisions of section 4031(e) [set out as a note below] shall apply with respect to

this section in the same manner as they apply to section 4031 [amending this section and enacting provisions set out as notes below].”

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104-191, title II, §271(d), Aug. 21, 1996, 110 Stat. 2036, provided that:

“(1) Except as provided in this subsection, the amendment made by subsection (a) [amending this section] shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101-508].

“(2)(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(vi)], 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 (as added by subsection (a)), after the date of the enactment of this Act [Aug. 21, 1996], 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 (as in effect before the date of the enactment of this Act), without the revision specified in such clause.”

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103-432, title I, §171(l), Oct. 31, 1994, 108 Stat. 4451, provided that: “The amendments made by this section [amending this section and sections 1320c-3, 1395b-2, and 1395b-4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes below] shall be effective as if included in the enactment of OBRA-1990 [Pub. L. 101-508]; except that—

“(1) the amendments made by subsection (d)(1) [amending this section] shall take effect on the date of the enactment of this Act [Oct. 31, 1994], but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)] (for an action occurring after the effective date of the amendments made by section 4354 of OBRA-1990 [see section 4354(c) of Pub. L. 101-508, set out as an Effective Date of 1990 Amendment note below] 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 [42 U.S.C. 1395ss(d)(3)(A)(i)(II)] (as amended by this section);

“(2) the amendments made by subsection (d)(2)(A) [amending this section] and by subparagraphs (A), (B), and (E) of subsection (e)(1) [amending this section] shall be effective on the date specified in subsection (m)(4) [set out as a note below]; and

“(3) the amendment made by subsection (g)(2) [amending 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 [42 U.S.C. 1395ss(s)(2)], for effective date see section 4357(b) of Pub. L. 101-508, set out as an Effective Date of 1990 Amendment note below] (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).”

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101-508, title IV, §4353(d)(2), Nov. 5, 1990, 104 Stat. 1388-130, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to policies mailed, or caused to be mailed, on and after July 1, 1991.”

Pub. L. 101-508, title IV, §4354(c), Nov. 5, 1990, 104 Stat. 1388-132, provided that: “The amendments made

by this section [amending this section] shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act [Nov. 5, 1990].”

Pub. L. 101-508, title IV, §4355(d), Nov. 5, 1990, 104 Stat. 1388-134, as amended by Pub. L. 103-432, title I, §171(e)(3), Oct. 31, 1994, 108 Stat. 4449, provided that: “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 [42 U.S.C. 1395ss(p)(1)(C)]) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act.”

Pub. L. 101-508, title IV, §4356(b), Nov. 5, 1990, 104 Stat. 1388-134, as amended by Pub. L. 103-432, title I, §171(f)(2), Oct. 31, 1994, 108 Stat. 4449, provided that: “The amendment made by subsection (a) [amending this section] shall take effect on the date specified in section 1882(p)(1)(C) of the Social Security Act [42 U.S.C. 1395ss(p)(1)(C)].”

Pub. L. 101-508, title IV, §4357(b), Nov. 5, 1990, 104 Stat. 1388-135, provided that: “The amendments made by subsection (a) [amending this section] shall take effect 1 year after the date of the enactment of this Act [Nov. 5, 1990].”

Amendment by section 4358(a), (b)(1), (2) of Pub. L. 101-508 only applicable in 15 States (as determined by Secretary of Health and Human Services) and such other States as elect such amendment to apply to them, and during the 6½-year period beginning with 1992, with such amendment to remain in effect beyond the 6½-year period unless the Secretary makes certain determinations, see section 4358(c) of Pub. L. 101-508, as amended, set out as a note under section 1320c-3 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101-234, title II, §203(e), Dec. 13, 1989, 103 Stat. 1985, provided that: “The provisions of this section [amending this section, enacting provisions set out as notes under sections 1395b-2 and 1395mm of this title, and amending provisions set out as a note under this section] shall take effect January 1, 1990, except that the amendment made by subsection (d) [amending provisions set out as an Effective Date of 1988 Amendment note under this section] shall be effective as if included in the enactment of MCCA [Pub. L. 100-360].”

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100-360, title II, §221(g), July 1, 1988, 102 Stat. 746, as amended by Pub. L. 100-485, title VI, §608(d)(12), Oct. 13, 1988, 102 Stat. 2415; Pub. L. 101-234, title II, §203(d), Dec. 13, 1989, 103 Stat. 1985, provided that:

“(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 [July 1, 1988].

“(2) The amendments made by subsections (a) and (b) [amending 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 [42 U.S.C. 1395ss(k)(1)(B), (2)(B)] (as added by subsection (d) of this section).

“(3) The amendment made by subsection (e) [amending 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 [42 U.S.C. 1395ss(b)(2)]) by not later than 90 days after the date of the enactment of this Act [July 1, 1988].”

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(i)(1)(B), (C) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

Amendment by section 428(b) of Pub. L. 100-360 effective July 1, 1988, and applicable only with respect to violations occurring on or after such date, see section 428(c) of Pub. L. 100-360, set out as an Effective Date note under section 1320b-10 of this title.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100-203, title IV, § 4081(c)(2), Dec. 22, 1987, 101 Stat. 1330-128, as amended by Pub. L. 100-360, title IV, § 411(i)(1)(D), (E), July 1, 1988, 102 Stat. 788; Pub. L. 100-485, title VI, § 608(d)(24)(A), Oct. 13, 1988, 102 Stat. 2421, provided that:

“(A) The amendments made by subsection (b) [amending 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 [42 U.S.C. 1395ss(c)(3)], 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.”

Amendment by Pub. L. 100-93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100-93, set out as a note under section 1320a-7 of this title.

EFFECTIVE DATE

Pub. L. 96-265, title V, § 507(b), June 9, 1980, 94 Stat. 481, provided that: “The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [June 9, 1980], except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act [42 U.S.C. 1395ss(d)(4)] (as added by this section) shall become effective on July 1, 1982.”

RULE OF CONSTRUCTION

Pub. L. 108-173, title I, § 104(c), Dec. 8, 2003, 117 Stat. 2165, provided that:

“(1) IN GENERAL.—Nothing in this Act [see Tables for classification] shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) [42 U.S.C. 1395ss] to participate as a PDP sponsor under part D of title XVIII of such Act [42 U.S.C. 1395w-101 et seq.], as added by section 101, as a condition for issuing such policy.

“(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) [42 U.S.C. 1395ss] to participate as a PDP sponsor under such part D as a condition for issuing such policy.”

IMPLEMENTATION OF NAIC RECOMMENDATIONS

Pub. L. 110-275, title I, § 104(a), July 15, 2008, 122 Stat. 2501, provided that:

“(1) IN GENERAL.—The Secretary of Health and Human Services (in this section [enacting section 1395ss-1 of this title and amending this section] referred to as the ‘Secretary’) shall provide for implementation of the changes in the NAIC model law and regulations approved by the National Association of Insurance Commissioners in its Model #651 (‘Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act’) on March 11, 2007, as modified to reflect the changes made under this Act

[see Short Title of 2008 Amendment note set out under section 1305 of this title] and the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233) [see Short Title note set out under section 2000ff of this title].

“(2) IMPLEMENTATION DATES.—

“(A) IN GENERAL.—The modifications to Model #651 required under paragraph (1) shall be completed by the National Association of Insurance Commissioners not later than October 31, 2008. Except as provided in subparagraph (B), each State shall have 1 year from the date the National Association of Insurance Commissioners adopts the revised NAIC model law and regulations (as changed by Model #651, as so modified) to conform the regulatory program established by the State to such revised NAIC model law and regulations.

“(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State which the Secretary determines requires State legislation in order to conform the regulatory program established by the State to such revised NAIC model law and regulations, the State shall not be regarded as failing to comply with the requirements of this section solely on the basis of its failure to meet such requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 15, 2008]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

“(C) TRANSITION DATES.—No carrier may issue a new or revised medicare supplemental policy or certificate under section 1882 of the Social Security Act (42 U.S.C. 1395ss) that meets the requirements of such revised NAIC model law and regulations for coverage effective prior to June 1, 2010. A carrier may continue to offer or issue a medicare supplemental policy under such section that meets the requirements of the NAIC model law and regulations and State law (as in effect prior to the adoption of such revised NAIC model law and regulations) prior to June 1, 2010. Nothing shall preclude carriers from marketing new or revised medicare supplemental policies or certificates that meet the requirements of such revised NAIC model law and regulations on or after the date on which the State conforms the regulatory program established by the State to such revised NAIC model law and regulations.”

STUDY OF MEDIGAP POLICIES

Pub. L. 106-113, div. B, § 1000(a)(6) [title V, § 553(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-393, provided that:

“(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 65½.

“(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.

“(2)(3) 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.”

CONFORMING BENEFITS TO CHANGES IN TERMINOLOGY
FOR HOSPITAL OUTPATIENT DEPARTMENT COST SHARING

Pub. L. 105-33, title IV, § 4031(f), Aug. 5, 1997, 111 Stat. 359, provided that: "For purposes of apply [sic] section 1882 of the Social Security Act (42 U.S.C. 1395ss) and regulations referred to in subsection (e) [set out as a note above], copayment amounts provided under section 1833(t)(5) of such Act [42 U.S.C. 1395(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."

TRANSITION PROVISIONS

Pub. L. 110-233, title I, § 104(d), May 21, 2008, 122 Stat. 903, provided that:

"(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 [amending 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 [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

"(2) NAIC STANDARDS.—If, not later than October 31, 2008, 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 [42 U.S.C. 1395ss] (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section [amending 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, not later than July 1, 2009, 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) July 1, 2009.

"(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 2009 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, 2009. 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."

Pub. L. 105-33, title IV, § 4031(e), Aug. 5, 1997, 111 Stat. 358, provided that:

"(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 sec-

tion [amending 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 [42 U.S.C. 1395ss] 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 [Aug. 5, 1997], 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 [42 U.S.C. 1395ss] (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) [set out as a note below] and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)(vi)(IV)], 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 [amending 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."

Pub. L. 104-191, title II, § 271(c), Aug. 21, 1996, 110 Stat. 2036, provided that:

"(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 [42 U.S.C. 1395ss(d)(3)(A)] 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 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 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 [Pub. L. 103-432, set out below] and before the end of the 30-day period beginning on the date of the enactment of this Act [Aug. 21, 1996], 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 (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.”

APPLICABILITY OF DISCLOSURE REQUIREMENT

Pub. L. 103-432, title I, §171(d)(3)(C), Oct. 31, 1994, 108 Stat. 4448, provided that: “The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(C)(ii)] 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.”

STATE REGULATORY PROGRAMS

Pub. L. 103-432, title I, §171(m), Oct. 31, 1994, 108 Stat. 4451, provided that:

“(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 [amending this section and sections 1320c-3, 1395b-2, and 1395b-4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes under 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 [42 U.S.C. 1395ss] 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 [Oct. 31, 1994], 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.

“(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.

“(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.”

EVALUATION OF 1990 AMENDMENTS

Pub. L. 101-508, title IV, §4358(d), Nov. 5, 1990, 104 Stat. 1388-137, provided that: “The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section [amending this section and section 1320c-3 of this title] and shall report to Congress on such evaluation by not later than January 1, 1995.”

§ 1395ss-1. Clarification

Any health insurance policy that provides reimbursement for expenses incurred for items and services for which payment may be made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] but which are not reimbursable by reason of the applicability of deductibles, coinsurance, copayments or other limitations imposed by a Medicare Advantage plan (including a Medicare Advantage private fee-for-service plan) under part C of such title [42 U.S.C. 1395w-21 et seq.] shall comply with the requirements of section 1882(o) of the such¹ Act (42 U.S.C. 1395ss(o)).

(Pub. L. 110-275, title I, §104(c), July 15, 2008, 122 Stat. 2502.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part C of title XVIII of the Act is classified to section 1395w-21 et seq. of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Medicare Improvements for Patients and Providers Act of 2008, and not as part of the Social Security Act which comprises this chapter.

§ 1395tt. Hospital providers of extended care services

(a) Hospital facility agreements; reasonable costs of services

(1) Any hospital which has an agreement under section 1395cc of this title may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this subchapter, payment to any hospital (other

¹ So in original.