provisions. By July 1992, all States had adopted standards equal to or more stringent than the 1991 NAIC model regulation for Medigap policies.

The Federal certification program applies exclusively to Medigap policies, as defined in section 1882 of the Act. State regulation, by contrast, includes a wider range of policies that might be sold to Medicare beneficiaries, including limited health benefit insurance such as indemnity, specified disease, and long term care policies. (In fact some States prohibit the sale of some types of policies that are the subject of this notice, such as specified disease policies). Section 1882 of the Act does, however, affect these policies, to the extent that they duplicate other coverage a beneficiary may have.

II. Anti-Duplication Provisions

A. Medigap Legislation Before 1990

Section 1882 of the Act contains a sanctions section that establishes criminal and civil money penalties designed to assist States and the Federal government in dealing with abuses identified in the various studies and investigations of Medigap insurance. Before OBRA '90 was enacted, penalties applied if an individual sold to a Medicare beneficiary any health insurance policy (that is, not just a Medigap policy) that was known to substantially duplicate the beneficiary's Medicare coverage or other health insurance. However, benefits that were payable without regard to the individual's other health benefit coverage were to be considered non-duplicative. Section 1882(d)(3)(C) of the Act further provided that the penalties for selling or issuing duplicative coverage did not apply to group policies or plans of employers or labor organizations.

B. The Omnibus Budget Reconciliation Act of 1990

Section 4354(a) of OBRA '90 amended section 1882(d)(3) of the Act to broaden the earlier anti-duplication provisions by making several significant changes. In section 1882(d)(3)(A) of the Act, it removed the qualifier ''substantially'' that modified ''duplicates'' in the earlier version of the Act. As a result, any amount of duplication became illegal. Section 4354(a) of OBRA '90 also deleted the original wording in section 1882(d)(3)(B) of the Act that provided that if the policy paid benefits without respect to other coverage (that is, the policy did not coordinate benefits with other coverage), it would be considered non-duplicative. Section 4354(a) of OBRA '90 also broadened the anti-duplication provisions to make it illegal to duplicate Medicaid as well as Medicare benefits or other private coverage. As amended by OBRA '90, section 1882(d)(3)(A) of the Act now made it:

> * * * unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled [including Medicare and Medicaid or any private coverage the individual might have] * * *

Under section 1882(d)(3)(C) of the Act, employer group health plans continued to be exempt from these requirements.

While the provisions of OBRA '90 were intended to protect Medicare beneficiaries from abusive sales practices and prevent them from buying unnecessary and expensive duplicate coverage, it became apparent soon after enactment that a total prohibition against any amount of duplication of benefits, including even any incidental overlap, had the unintended effect of denying Medigap or other types of desired coverage, such as long term care insurance policies, to people who already had some coverage that would be at least partially duplicated by the new policy. This was true even in cases in which the beneficiary had good reasons for wanting to buy the additional coverage.

C. Social Security Act Amendments of 1994

The Social Security Act Amendments of 1994 (SSAA '94) (Public Law 103–432) retained, in section 1882(d)(3)(A)(i)(I) of the Act, the basic prohibition against selling or issuing to a Medicare beneficiary a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is entitled under Medicare or Medicaid. However, the new law provides an exception to this basic prohibition.

The penalties for selling a policy that duplicates Medicare or Medicaid benefits (other than a Medigap policy to an individual entitled to any Medicaid benefits) do not apply if two conditions are met. First, all benefits under the policy must be fully payable directly to, or on behalf of, the beneficiary without regard to other health benefit coverage of the individual. Second, the issuer must display in a prominent manner as part of (or together with) the application a prescribed statement disclosing the extent to which benefits payable under the policy or plan duplicate Medicare benefits. The latter requirement only applies to policies sold or issued more than 60 days after the date that the required statements are published or promulgated under the provisions established in section 171(d)(3)(D) of SSAA '94. Therefore policies issued on or after August 11, 1995 must include these disclosure statements.

Section 171(d)(3)(D) of SSAA '94 provides that if, within 90 days of the statute's enactment, the NAIC develops and submits to the Secretary a statement for each type of non-Medigap health insurance policy and the Secretary approves all the statements as meeting the requirements of SSAA '94, the statements developed by the NAIC will be the ones prescribed by the law. The statute instructs the NAIC to consult with consumer and insurance industry representatives in developing the statements. The statute also specifies that the separate types of health insurance policies that need disclosure statements include, but are not limited to, fixed cash indemnity policies and specified disease policies. The statute gives the Secretary 30 days to review and approve or disapprove all the statements submitted by the NAIC. Upon approval of these statements the statute requires the Secretary to publish the statements.

III. Implementation of SSAA '94

A. Development of Disclosure Statements

In an effort to assure that consumer and insurance industry representatives had an opportunity to provide meaningful input into the NAIC's development of the disclosure statements, the NAIC undertook the following steps:

- On November 1, 1994, a Request for Comment was mailed to over 500 representatives of consumer organizations and insurance industry representatives as well as to the program directors of the Insurance Counseling and Assistance Programs established in each State.
- A Request for Comment was also sent to all NAIC members and the person responsible for health issues in each State as well as to all members of Congress and certain congressional health staff members.
- The Fall edition of the *NAIC NEWS* and the *NAIC Senior Counseling Letter* included a short summary of the major components of section 171 of the SSAA '94 (in particular, the provisions on duplication) and solicited input from the readers. These solicitations generated 33 written comment letters providing suggestions on how the NAIC should proceed.