

Assembly Bill No. 151

CHAPTER 270

An act to amend Sections 1358.11 and 1358.12 of the Health and Safety Code, and to amend Sections 10192.11 and 10192.12 of the Insurance Code, relating to health care coverage.

[Approved by Governor September 7, 2011. Filed with
Secretary of State September 7, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 151, Monning. Medicare supplement coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires plans and insurers that issue Medicare supplement contracts or policies, as defined, to comply with specified requirements.

Existing law requires issuers to make available to specified individuals who are 64 years of age or younger and who do not have end-stage renal disease, Medicare supplement benefit plans A, B, C, and F, and Medicare supplement benefit plan H, I, or J, or Medicare supplement benefit plan K or L, as specified. Existing federal law prohibits the issuance of new Medicare supplement plans H, I, and J, and instead authorizes the issuance of Medicare supplement plans M and N, as specified.

This bill would delete from those provisions obsolete references to plans H, I, and J, and instead require the issuer to make available Medicare supplement benefit plans A, B, C, and F, and Medicare supplement benefit plan K or L, or Medicare supplement benefit plan M or N, as specified.

Existing law prohibits an issuer from denying Medicare supplement coverage to an eligible individual who is guaranteed issue under specified circumstances. Existing law requires certain eligible individuals to be guaranteed issue of Medicare supplement plan A, B, C, F (including a high deductible plan F), K, or L.

This bill would add to that guaranteed issue requirement Medicare supplement plans M and N.

Existing law provides that an individual enrolled in a Medicare Advantage plan (Medicare Part C) that reduces any of its benefits, or increases cost sharing, or terminates certain relationships with providers, is eligible for Medicare supplement coverage that is issued by the same issuer of his or her Medicare Advantage plan or by a subsidiary of, or a network that contracts with, the parent company of that issuer.

This bill would extend that eligibility to an individual enrolled in a Medicare Advantage plan that increases its premium. The bill would provide that an individual enrolled in a Medicare Advantage plan is eligible for specified Medicare supplement coverage from any issuer under the circumstances described above if the issuer of his or her Medicare Advantage plan, or the subsidiary or network of the parent company, does not offer any other Medicare supplement coverage and only offers a Medicare Advantage plan or plans, and other specified conditions are met.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1358.11 of the Health and Safety Code is amended to read:

1358.11. (a) (1) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a contract that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(3) This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage

of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.

(c) Except as provided in subdivision (b) and Section 1358.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, including coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included covered persons.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g) (1) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment

period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare Advantage plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h) (1) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(2) For purposes of this subdivision, the following provisions shall apply:

(A) A 1990 standardized Medicare supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan A.

(B) A 1990 standardized Medicare supplement benefit plan B shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan B.

(C) A 1990 standardized Medicare supplement benefit plan C shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan C.

(D) A 1990 standardized Medicare supplement benefit plan D shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(E) A 1990 standardized Medicare supplement benefit plan E shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan D.

(F) (i) A 1990 standardized Medicare supplement benefit plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(G) A 1990 standardized Medicare supplement benefit plan G shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(H) A 1990 standardized Medicare supplement benefit plan H shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(I) A 1990 standardized Medicare supplement benefit plan I shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(J) (i) A 1990 standardized Medicare supplement benefit plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(K) A 1990 standardized Medicare supplement benefit plan K shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan K.

(L) A 1990 standardized Medicare supplement benefit plan L shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan L.

(i) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, he or she meets one of the following requirements:

(1) He or she is no longer eligible for Medi-Cal benefits.

(2) He or she is only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that he or she has not met the share of cost.

SEC. 2. Section 1358.12 of the Health and Safety Code is amended to read:

1358.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who seek to enroll under the contract during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement contract described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement contract because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement contract.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and either of the following applies:

(A) The plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(B) The employer no longer provides the individual with insurance that covers all of the payment for the 20-percent coinsurance.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

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

(D) (i) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement contract issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement contract is available to the individual from the same issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer, the individual shall be eligible for a Medicare supplement contract pursuant to paragraph (1) of subdivision (e) issued by any issuer, if the Medicare Advantage plan in which the individual is enrolled does any of the following:

(I) Increases the premium by 15 percent or more.

(II) Increases physician, hospital, or drug copayments by 15 percent or more.

(III) Reduces any benefits under the plan.

(IV) Discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.

(ii) Enrollment in a Medicare supplement contract from an issuer unaffiliated with the issuer of the Medicare Advantage plan in which the individual is enrolled shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual. Nothing in this section shall be construed to authorize an individual to enroll in a group Medicare supplement policy if the individual does not meet the eligibility requirements for the group.

(E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(F) The individual meets other exceptional conditions as the secretary may provide.

(3) The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the federal Social Security Act, and circumstances similar to those described in paragraph (2) exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

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

(iv) An organization under a Medicare Select policy.

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) The individual is enrolled under a Medicare supplement contract, and the enrollment ceases because of any of the following circumstances:

(A) The insolvency of the issuer or bankruptcy of the nonissuer organization, or other involuntary termination of coverage or enrollment under the contract.

(B) The issuer of the contract substantially violated a material provision of the contract.

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the contract's provisions in marketing the contract to the individual.

(6) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the federal Social Security Act, or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

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

(8) The individual while enrolled under a Medicare supplement contract that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement contract, and submits evidence of enrollment in Medicare Part D along with the application for a contract described in paragraph (4) of subdivision (e).

(c) (1) In the case of an individual described in paragraph (1) of subdivision (b), the guaranteed issue period begins on the later of the following two dates and ends on the date that is 63 days after the date the applicable coverage terminated:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no notice is received, the date of the notice denying a claim because of a termination or cessation of benefits.

(B) The date that the applicable coverage terminates or ceases.

(2) In the case of an individual described in paragraphs (2), (3), (4), (6), and (7) of subdivision (b) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subparagraph (A) of paragraph (5) of subdivision (b), the guaranteed issue period begins on the earlier of the following two dates and ends on the date that is 63 days after the date the coverage is terminated:

(A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any.

(B) The date that the applicable coverage is terminated.

(4) In the case of an individual described in paragraph (2), (3), (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of, subdivision (b) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of the disenrollment.

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the federal Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment period for Medicare Part D and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b), shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement contract in which he or she was most recently enrolled, if available from the same issuer. If that contract is not available, the eligible individual is entitled to a Medicare supplement

contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement contract with an outpatient prescription drug benefit, is entitled to a Medicare supplement contract that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, L, M, or N that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement contract offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N and that is offered and is available for issuance to a new enrollee by the same issuer that issued the individual's Medicare supplement contract with outpatient prescription drug coverage.

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy or contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy or contract, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated within 10 working days of the date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an enrollee or subscriber paid in advance and shall terminate coverage upon the request of an enrollee or subscriber.

SEC. 3. Section 10192.11 of the Insurance Code is amended to read:

10192.11. (a) (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from

an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(3) This section and Section 10192.12 do not prohibit an issuer in determining premium rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification. This section shall not be construed as preventing the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10192.8 or paragraph (1) of subdivision (a) of Section 10192.81.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the commissioner.

(c) Except as provided in subdivision (b) and Section 10192.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility. Every issuer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that issuer at the time of application. Issuers shall not discourage sales during the open enrollment period by any means, including the altering of the commission structure.

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, including, but not limited to, coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(g) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

(h) (1) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. An issuer shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(2) For purposes of this subdivision, the following provisions shall apply:

(A) A 1990 standardized Medicare supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan A.

(B) A 1990 standardized Medicare supplement benefit plan B shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan B.

(C) A 1990 standardized Medicare supplement benefit plan C shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan C.

(D) A 1990 standardized Medicare supplement benefit plan D shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(E) A 1990 standardized Medicare supplement benefit plan E shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan D.

(F) (i) A 1990 standardized Medicare supplement benefit plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(G) A 1990 standardized Medicare supplement benefit plan G shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(H) A 1990 standardized Medicare supplement benefit plan H shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(I) A 1990 standardized Medicare supplement benefit plan I shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(J) (i) A 1990 standardized Medicare supplement benefit plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(K) A 1990 standardized Medicare supplement benefit plan K shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan K.

(L) A 1990 standardized Medicare supplement benefit plan L shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan L.

(i) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, he or she meets one of the following requirements:

(1) He or she is no longer eligible for Medi-Cal benefits.

(2) He or she is only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that he or she has not met the share of cost.

SEC. 4. Section 10192.12 of the Insurance Code is amended to read:

10192.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement policy, eligible persons are those individuals described in subdivision (b) who seek to enroll under the policy during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement policy.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and either of the following applies:

(A) The plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(B) The employer no longer provides the individual with insurance that covers all of the payment for the 20-percent coinsurance.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

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

(D) (i) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement policy issued by the

same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement policy is available to the individual from the same issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer, the individual shall be eligible for a Medicare supplement policy pursuant to paragraph (1) of subdivision (e) issued by any issuer, if the Medicare Advantage plan in which the individual is enrolled does any of the following:

(I) Increases the premium by 15 percent or more.

(II) Increases physician, hospital, or drug copayments by 15 percent or more.

(III) Reduces any benefits under the plan.

(IV) Discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.

(ii) Enrollment in a Medicare supplement contract from an issuer unaffiliated with the issuer of the Medicare Advantage plan in which the individual is enrolled shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual. Nothing in this section shall be construed to authorize an individual to enroll in a group Medicare supplement policy if the individual does not meet the eligibility requirements for the group.

(E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(F) The individual meets other exceptional conditions as the secretary may provide.

(3) The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the federal Social Security Act, and circumstances similar to those described in paragraph (2) exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

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

(iv) An organization under a Medicare Select policy.

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) The individual is enrolled under a Medicare supplement policy, and the enrollment ceases because of any of the following circumstances:

(A) The insolvency of the issuer or bankruptcy of the nonissuer organization, or other involuntary termination of coverage or enrollment under the policy.

(B) The issuer of the policy substantially violated a material provision of the policy.

(C) 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.

(6) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the federal Social Security Act, or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

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

(8) The individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (4) of subdivision (e).

(c) (1) In the case of an individual described in paragraph (1) of subdivision (b), the guaranteed issue period begins on the later of the following two dates and ends on the date that is 63 days after the date the applicable coverage terminates:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no notice is received, the date of the notice denying a claim because of a termination or cessation of benefits.

(B) The date that the applicable coverage terminates or ceases.

(2) In the case of an individual described in paragraphs (2), (3), (4), (6), and (7) of subdivision (b) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subparagraph (A) of paragraph (5) of subdivision (b), the guaranteed issue period begins on the earlier of the following two dates and ends on the date that is 63 days after the date the coverage is terminated:

(A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any.

(B) The date that the applicable coverage is terminated.

(4) In the case of an individual described in paragraph (2), (3), (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of, subdivision (b) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of the disenrollment.

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the federal Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment period for Medicare Part D and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b) shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement policy in which he or she was most recently enrolled, if available from the same issuer. If that policy is not available, the eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit is entitled to a Medicare supplement policy that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, L, M, or N that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement policy offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, L, M, or N and that is offered and is available for issuance to a new enrollee by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement policies under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). The notice shall be communicated

within 10 working days of the date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an insured paid in advance and shall terminate coverage upon the request of an insured.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.