ASSEMBLY BILL No. 1543

Introduced by Committee on Health (Jones (Chair), Fletcher (Vice Chair), Adams, Ammiano, Block, Carter, Conway, De La Torre, Emmerson, Hall, Hayashi, Hernandez, Bonnie Lowenthal, Nava, V. Manuel Perez, Salas, and Audra Strickland)

March 4, 2009

An act to amend Sections 785, 10192.4, 10192.6, 10192.8, 10192.9, 10192.11, 10192.12, 10192.13, 10192.17, 10192.18, 10192.20 of, and to add Sections 10192.81, 10192.91, and 10192.24 to, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1543, as introduced, Committee on Health. Medicare supplement coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. 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.

The federal Medicare Improvements for Patients and Providers Act of 2008 requires states to adopt, by September 24, 2009, certain modernization changes to Medicare supplement policies made in a specified model law developed by the National Association of Insurance Commissioners.

In addition, the federal Genetic Information Nondiscrimination Act of 2008, prohibits an issuer of a Medicare supplemental policy from denying or conditioning the issuance or effectiveness of the policy, and from discriminating in the pricing of the policy, on the basis of genetic information, as specified. The act further prohibits an issuer of a Medicare supplemental policy from, among other things, requesting or requiring an individual or a family member of that individual to undergo a genetic test, as specified. The act requires states to make changes needed to conform to these requirements by July 1, 2009.

With respect to health insurers that issue Medicare supplement policies, this bill would make those conforming changes and would adopt the modernization changes made in the model law developed by the National Association of Insurance Commissioners. The bill would declare the intent of the Legislature to make the same changes to the Knox-Keene Act.

Existing law authorizes a Medicare supplement policy to limit coverage exclusively to a single disease or affliction.

This bill would instead require a Medicare supplement policy to cover the applicable coinsurance and deductible for any illness or disease covered by Medicare, plus expenses for any illness or disease covered by the individual's applicable Medicare supplement plan.

Existing law provides that a person is eligible for the guaranteed issue of a Medicare supplement plan if the person is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.

This bill would instead provide that a person is eligible for the guaranteed issue of a Medicare supplement plan if the person is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or ceases to provide some, all, or substantially all of those supplemental health benefits, or the employer no longer provides the individual with insurance that covers all of the payment for the Part B 20% coinsurance.

Existing law prohibits an issuer from requiring or requesting health information from an applicant who is guaranteed Medicare supplement coverage and from requiring or requesting that applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996.

This bill would instead prohibit an issuer from using the applicant's health information for the purpose of determining eligibility for coverage.

The bill would make other conforming and technical changes.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 785 of the Insurance Code is amended to read:

785. (a) All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

(b) Conduct of an insurer, broker, or agent, or other person engaged in the transaction of insurance, during the offer and sale of a policy or certificate previous to the purchase is relevant to any action alleging a breach of the duty of good faith and fair dealing.

(c) Except where explicitly provided to the contrary, this article shall not apply to any of the following:

(1) Medicare supplement insurance as defined in subdivision ~~(l)~~ *(m)* of Section 10192.4.

(2) Long-term care insurance as defined in Section 10231.2.

(3) Disability coverage provided through the insured's employer or former employer.

(4) Disability insurance policies or certificates principally designed to provide coverage for accidents or expenses incurred while traveling if the premium for the policy or certificate is ten dollars ($10) or less.

(5) Blanket disability insurance as defined in Section 10270.3.

(6) Credit disability insurance as defined in Section 779.2.

(7) Accidental death insurance.

(8) Until January 1, 2002, disability policies or certificates that are sold through direct response methods of delivery.

(9) Disability income insurance as defined in subdivision (i) of Section 799.01.

(d) Provided that the requirements of Section 10296 are met, this article shall not apply to transportation ticket policies and baggage insurance policy types allowable for sale by travel agents pursuant to Section 1753.

SEC. 2. Section 10192.4 of the Insurance Code is amended to read:

10192.4. The following definitions apply for the purposes of this article:

(a) "Applicant" means:

(1) The person who seeks to contract for insurance benefits, in the case of an individual Medicare supplement policy.

(2) The proposed certificate holder, in the case of a group Medicare supplement policy.

(b) "Bankruptcy" means that situation in which a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(c) "Certificate" means a certificate issued for delivery in this state under a group Medicare supplement policy.

(d) "Certificate form" means the form on which the certificate is issued for delivery by the issuer.

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

(f) (1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) Any individual or group contract, policy, certificate, or program that is written or administered by a health care service plan, health insurer, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage.

(B) Part A or B of Title XVIII of the federal Social Security Act (Medicare).

(C) Title XIX of the federal Social Security Act ~~(Medicaid)~~ *(Medicaid (known as Medi-Cal in California))*, other than coverage consisting solely of benefits under Section 1928 of that act.

(D) Chapter 55 of Title 10 of the United States Code (CHAMPUS).

(E) A medical care program of the Indian Health Service or of a tribal organization.

(F) A state health benefits risk pool.

(G) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program).

(H) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

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

(J) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(K) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

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

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

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(g) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

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

(i) "Issuer" includes insurance companies, fraternal benefit societies, and any other entity delivering, or issuing for delivery, Medicare supplement policies or certificates in this state, except entities subject to Article 3.5 (commencing with Section 1358) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(j) "Medi-Cal" means California's version of Medicaid under Title XIX of the federal Social Security Act.

~~(j)~~

(k) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

~~(k)~~

(l) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by

provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.

(3) Medicare Advantage private fee-for-service plans.

~~(l)~~

(m) "Medicare supplement policy" means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395mm) or an issued policy under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the Social Security Act.

~~(m)~~

(n) "Policy form" means the form on which the policy is issued for delivery by the issuer.

(o) "Prestandardized Medicare supplement benefit plan," "prestandardized benefit plan," or "prestandardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 21, 1992.

(p) "1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 21, 1992, and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(q) "2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan," or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

~~(n)~~

(r) "Secretary" means the Secretary of the United States Department of Health and Human Services.

SEC. 3. Section 10192.6 of the Insurance Code is amended to read:

10192.6. (a) Except for permitted preexisting condition clauses as described in Sections 10192.7 ~~and~~, 10192.8, *and 10192.81*, a policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) A Medicare supplement policy or certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) A Medicare supplement policy or certificate in force shall not contain benefits that duplicate benefits provided by Medicare.

(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 10192.8, a Medicare supplement policy with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current policyholders, at the option of the policyholder, who do not enroll in Medicare Part D.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement policy with benefits for outpatient prescription drugs shall not be renewed after the policyholder enrolls in Medicare Part D unless both of the following conditions exist:

(A) The policy is modified to eliminate outpatient prescription drug coverage for outpatient prescription drug expenses incurred after the effective date of the individual's coverage under a Medicare Part D plan.

(B) The premium is adjusted to reflect the elimination of outpatient prescription drug coverage at the time of enrollment in Medicare Part D, accounting for any claims paid if applicable.

SEC. 4. Section 10192.8 of the Insurance Code is amended to read:

10192.8. The following standards are applicable to all Medicare supplement policies or certificates advertised, solicited, or issued for delivery on or after January 1, 2001, *and prior to June 1, 2010*. A policy or certificate shall not be advertised, solicited, or issued

for delivery as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(a) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article:

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

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

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible~~ amount and copayment percentage factors~~, *copayment, or coinsurance amounts*. Premiums may be modified to correspond with those changes.

(4) A Medicare supplement policy or certificate shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable or noncancelable.

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or misrepresentation which is shown by the issuer to be material to the acceptance for coverage. The contestability period for Medicare supplement insurance shall be two years.

(C) If the Medicare supplement policy is terminated by the master policyholder and is not replaced as provided under subparagraph (E), the issuer shall offer certificate holders an individual Medicare supplement policy that, at the option of the certificate holder, either provides for continuation of the benefits

contained in the group policy or provides for benefits that otherwise meet the requirements of one of the standardized policies defined in this article.

(D) If an individual is a certificate holder in a group Medicare supplement policy and membership in the group is terminated, the issuer shall either offer the certificate holder the conversion opportunity described in subparagraph (C) or, at the option of the group policyholder, shall offer the certificate holder continuation of coverage under the group policy.

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

(ii) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate that has been in force for six months or more, the replacing issuer shall not impose an exclusion or limitation based on a preexisting condition. If the original coverage has been in force for less than six months, the replacing issuer shall waive any time period applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate to the extent the time was spent under the original coverage.

(F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), the policy as modified as a result of that act shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7) (A) (i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to Medi-Cal ~~or Medicaid under Title XIX of the federal Social Security Act~~, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the insurer shall return directly to the insured that portion of the premium attributable to the period of Medi-Cal ~~or Medicaid~~ eligibility, subject to adjustment for paid claims. If suspension occurs and if the policyholder or certificate holder loses entitlement to Medi-Cal ~~or Medicaid~~, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement, or equivalent coverage shall be provided if the prior form is no longer available.

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

(B) Reinstitution of coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for a

Medicare Part D enrollee shall not include coverage for outpatient prescription drugs but shall otherwise provide coverage that is substantially equivalent to the coverage in effect before the date of suspension.

(iii) Shall provide for classification of premiums on terms 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 not been suspended.

(8) If an issuer makes a written offer to the Medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 standardized plan, as described in Section 10192.9, to a 2010 standardized plan, as described in Section 10192.91, the offer and subsequent exchange shall comply with the following requirements:

(A) An issuer need not provide justification to the commissioner if the insured replaces a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of that offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner.

(B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(C) An issuer shall not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy. This subdivision shall not apply to an applicant who is guaranteed issue under Section 10192.11 or 10192.12.

(D) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

~~(8) No~~

(9) A Medicare supplement policy ~~may limit coverage exclusively to a single disease or affliction~~ *shall cover the applicable coinsurance and deductible for any illness or disease covered by Medicare, plus expenses for any illness or disease covered by the individual's applicable Medicare supplement plan*.

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. ~~However, the benefits described in paragraphs (6) and (7) shall not be offered so long as California is required to disallow these benefits for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under Section 1395ss of Title 42 of the United States Code.~~

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of the actual cost, up to the legally billed amount, of an annual mammogram as provided in Section 10123.81, to the extent not paid by Medicare.

(7) Coverage of the actual cost, up to the legally billed amount, of an annual cervical cancer screening test as provided in Section 10123.18, to the extent not paid by Medicare.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B to J, inclusive, only as provided by Section 10192.9.

(1) With respect to the Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) With respect to the Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) With respect to 80 percent of the Medicare Part B excess charges, coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge. If the insurer limits payment to a limiting charge, the insurer has the burden to establish that amount as the legal limit.

(5) With respect to 100 percent of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge. If the insurer limits payment to a limiting charge, the insurer has the burden to establish that amount as the legal limit.

(6) With respect to the basic outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no

Medicare supplement policy may be sold or issued if it includes a prescription drug benefit.

(7) With respect to the extended outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement policy may be sold or issued if it includes a prescription drug benefit.

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

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

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures.

(B) The following screening tests or preventive services that are not covered by Medicare, the selection and frequency of which are determined to be medically appropriate by the attending physician:

(i) Fecal occult blood test.

(ii) Mammogram.

(C) Influenza vaccine administered at any appropriate time during the year.

(10) With respect to the at-home recovery benefit, coverage for the actual charges up to forty dollars ($40) per visit and an annual maximum of one thousand six hundred dollars ($1,600) per year to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

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

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, or a personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

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

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

(B) With respect to coverage requirements and limitations, the following shall apply:

(i) At-home recovery services provided shall be primarily services that assist in activities of daily living.

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

(iii) Coverage is limited to the following:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number

of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

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

(III) One thousand six hundred dollars ($1,600) per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in subparagraph (A).

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(C) Coverage is excluded for the following:

(i) Home care visits paid for by Medicare or other government programs.

(ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(d) The standardized Medicare supplement benefit plan "K" shall consist of the following benefits:

(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment for this benefit as payment in full and shall not bill the insured for any balance.

(4) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible

amount per benefit period until the out-of-pocket limitation described in paragraph (10) is met.

(5) With respect to skilled nursing facility care, coverage for 50 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (10) is met.

(6) With respect to hospice care, coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (10) is met.

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (10) is met.

(8) Except for coverage provided in paragraph (9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible, until the out-of-pocket limitation is met as described in paragraph (10).

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services, after the policyholder pays the Medicare Part B deductible.

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(e) The standardized Medicare supplement benefit plan "L" shall consist of the following benefits:

(1) The benefits described in paragraphs (1), (2), (3), and (9) of subdivision (d).

(2) With respect to the Medicare Part A deductible, coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (8) is met.

(3) With respect to skilled nursing facility care, coverage for 75 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (8) is met.

(4) With respect to hospice care, coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (8) is met.

(5) Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (8) is met.

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.

(7) Coverage for 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(8) Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars ($2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(f) An issuer shall prominently indicate through text edits, or by other means acceptable to the commissioner, an amendment made to a Medicare supplement policy form that the department previously approved on the basis that the amendment is consistent with this section. The department may, in its discretion, restrict its review to amendments made to Medicare supplement policy forms that have not previously been found consistent with this section in order to facilitate the availability of amended policy forms that are consistent with the federal Medicare Modernization Act. The department shall not restrict its review if the amendment makes additional changes to the Medicare supplement policy form.

SEC. 5. Section 10192.81 is added to the Insurance Code, to read:

10192.81. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of Section 10192.8.

(a) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article.

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

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

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) A Medicare supplement policy or certificate shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material

misrepresentation which is shown by the issuer to be material to the acceptance for coverage. The contestability period for Medicare supplement insurance shall be two years.

(C) If the Medicare supplement policy is terminated by the master policyholder and is not replaced as provided under subparagraph (E), the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder, does one of the following:

(i) Provides for continuation of the benefits contained in the group policy.

(ii) Provides for benefits that otherwise meet the requirements of one of the standardized policies defined in this article.

(D) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall do one of the following:

(i) Offer the certificate holder the conversion opportunity described in subparagraph (C).

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

(ii) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate that has been in force for six months or more, the replacing issuer shall not impose an exclusion or limitation based on a preexisting condition. If the original coverage has been in force for less than six months, the replacing issuer shall waive any time period applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate to the extent the time was spent under the original coverage.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the

duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) (A) (i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Medi-Cal, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the insurer shall return directly to the insured that portion of the premium attributable to the period of Medi-Cal eligibility, subject to adjustment for paid claims.

(ii) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under Medi-Cal, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement or equivalent coverage shall be provided if the prior form is no longer available.

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

(B) Reinstitution of coverages shall comply with all of the following requirements:

(i) Not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(iii) Provide for classification of premiums on terms 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 not been suspended.

(8) A Medicare supplement policy shall cover the applicable coinsurance and deductible for any illness or disease covered by Medicare, plus expenses for any illness or disease covered by the individual's applicable Medicare supplement plan.

(b) Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic (core) package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(7) Coverage of the actual cost, up to the legally billed amount, of an annual mammogram as provided in Section 10123.81, to the extent not paid by Medicare.

(8) Coverage of the actual cost, up to the legally billed amount, of an annual cervical cancer screening test as provided in Section 10123.18, to the extent not paid by Medicare.

(c) The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided in Section 10192.91:

(1) With respect to the Medicare Part A deductible, coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) With respect to the Medicare Part B deductible, coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) With respect to Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this

benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

SEC. 6. Section 10192.9 of the Insurance Code is amended to read:

10192.9. ~~(a)~~ *The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state prior to June 1, 2010.*

(a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subdivision (b) of Section 10192.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted by subdivision (f) and by Section 10192.10.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A to J, inclusive, listed in subdivision (e), and shall conform to the definitions in Section 10192.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b), (c), (d), and (e) of Section 10192.8 and list the benefits in the order listed in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subdivision (c), other designations to the extent permitted by law.

(e) With respect to the makeup of benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit plan A shall be limited to the basic (core) benefit common to all benefit plans, as defined in subdivision (b) of Section 10192.8.

(2) Standardized Medicare supplement benefit plan B shall include only the following: the core benefit, plus the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 10192.8.

(3) Standardized Medicare supplement benefit plan C shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign

country as defined in paragraphs (1), (2), (3), and (8) of subdivision (c) of Section 10192.8, respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (8), and (10) of subdivision (c) of Section 10192.8, respectively.

(5) Standardized Medicare supplement benefit plan E shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of Section 10192.8, respectively.

(6) Standardized Medicare supplement benefit plan F shall include only the following: the core benefit, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(8) Standardized Medicare supplement benefit plan G shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (4), (8), and (10) of *subdivision (c) of* Section 10192.8, respectively.

(9) Standardized Medicare supplement benefit plan H shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (6), and (8) of *subdivision (c) of* Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(10) Standardized Medicare supplement benefit plan I shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(11) Standardized Medicare supplement benefit plan J shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(12) Standardized Medicare supplement benefit high deductible plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit, plus

the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8, respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(13) Standardized Medicare supplement benefit plan K shall consist of only those benefits described in subdivision (d) of Section 10192.8.

(14) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in subdivision (e) of Section 10192.8.

(f) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, that are not otherwise available and that are cost-effective and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. On and after January 1, 2006, the innovative benefit shall not include an outpatient prescription drug benefit.

SEC. 7. Section 10192.91 is added to the Insurance Code, to read:

10192.91. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or

certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of Section 10192.9.

(a) (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subdivision (b) of Section 10192.81.

(2) If an issuer makes available any of the additional benefits described in subdivision (c) of Section 10192.81, or offers standardized benefit Plans K or L, as described in paragraphs (8) and (9) of subdivision (e), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in paragraph (1), a policy form or certificate form containing either standardized benefit Plan C, as described in paragraph (3) of subdivision (e), or standardized benefit Plan F, as described in paragraph (5) of subdivision (e).

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subdivision (f) and by Section 10192.10.

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in subdivision (e) and conform to the definitions in Section 10192.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b) and (c) of Section 10192.81; or, in the case of plan K or L, in paragraph (8) or (9) of subdivision (e) and list the benefits in the order shown in subdivision (e). For purposes of this section, “structure, language, and format” means style, arrangement, and overall content of a benefit.

(d) In addition to the benefit plan designations required in subdivision (c) of this section, an issuer may use other designations to the extent permitted by law.

(e) With respect to the make-up of 2010 standardized benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit Plan A shall include only the basic (core) benefits as defined in subdivision (b) of Section 10192.81.

(2) Standardized Medicare supplement benefit Plan B shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 10192.81.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (3), (4), and (6) of subdivision (c) of Section 10192.81, respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: the basic (core) benefit, as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 10192.81, respectively.

(5) Standardized Medicare supplement Plan F shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (3), (4), (5), and (6) of subdivision (c) of Section 10192.81, respectively.

(6) Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph (B).

(A) The covered expenses include the basic (core) benefit as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary

emergency care in a foreign country as defined in paragraphs (1), (3), (4), (5), and (6) of subdivision (c) of Section 10192.81, respectively.

(B) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars ($1,500) and shall be adjusted annually from 1999 by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (3), (5), and (6) of subdivision (c) of Section 10192.81, respectively.

(8) Standardized Medicare supplement Plan K shall include only the following:

(A) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period.

(B) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period.

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance.

(D) Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J).

(E) Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of pocket limitation is met as described in subparagraph (J).

(F) Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of pocket limitation is met as described in subparagraph (J).

(G) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (J).

(H) Except for coverage provided in subparagraph (I), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J).

(I) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(J) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the United States Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L shall include only the following:

(A) The benefits described in subparagraphs (A), (B), (C), and (I) of paragraph (8).

(B) The benefit described in subparagraphs (D), (E), (F), (G), and (H) of paragraph (8), but substituting 75 percent for 50 percent.

(C) The benefit described in subparagraph (J) of paragraph (8), but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(10) Standardized Medicare supplement Plan M shall include only the following: the basic (core) benefit as defined in

subdivision (b) of Section 10192.81, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (2), (3), and (6) of subdivision (c) of Section 10192.81, respectively.

(11) Standardized Medicare supplement Plan N shall include only the following: the basic (core) benefit as defined in subdivision (b) of Section 10192.81, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 10192.81, respectively, with copayments in the following amounts:

(A) The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(B) The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(f) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

SEC. 8. 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 H, I, or J, if currently available, and commencing January 1, 2007, shall make available to them Medicare supplement benefit plan K or L, if currently available. The selection among Medicare supplement plan H, I, or J and the selection between Medicare supplement benefit plan K or L 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 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) 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.

(i) Commencing January 1, 2007, an individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for benefits*, including benefits with a share of cost,* under the Medi-Cal program because of an increase in the individual's income or assets.

SEC. 9. 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 the plan ~~either~~ terminates, or *the plan* ceases to provide *some, all, or substantially* all of those supplemental health benefits to the individual, *or the employer no longer provides the individual with insurance that covers all of the payment for the Part B 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, or the plan is terminated for all individuals within a residence area.

(D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing 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.

(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 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 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 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 Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the 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 age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the 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 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, or L 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, or L 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, or L 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, or L 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. 10. Section 10192.13 of the Insurance Code is amended to read:

10192.13. (a) An issuer shall comply with Section 1882(c)(3) of the federal Social Security Act (as enacted by Section

4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act of 1987 (OBRA), Public Law 100-203) by doing all of the following and by certifying compliance on the Medicare supplement insurance experience reporting form:

(1) Accepting a notice from a Medicare *administrative contractor, formally known as a fiscal intermediary or* carrier, on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(3) Paying the participating physician or supplier directly.

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare ~~carrier~~ *administrative contractors* may be sent.

(5) Paying user fees for claim notices that are transmitted electronically or otherwise.

(6) Providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare ~~carriers~~ *administrative contractors*.

(7) File, by June 30 of each year, with the commissioner a list of its Medicare supplement policies and certificates offered or issued or in force in California as of the end of the previous year.

(A) The list shall identify the issuer by name and address, shall identify each type of form it offers by name and form number, and shall differentiate between forms approved in the previous calendar year and those approved before the previous calendar year.

(B) The list shall identify all of the following:

(i) Forms issued and in force but no longer offered in California.

(ii) Forms that, for any reason, were not filed and approved by the commissioner.

(iii) Forms for which the commissioner's approval was withdrawn within the previous calendar year.

(iv) The number of forms issued in California in the previous calendar year, and the number of forms in force in California on December 31 of the previous calendar year.

(b) (1) Compliance with the requirements set forth in subdivision (a) shall be certified on the Medicare supplement insurance experience reporting form provided by the commissioner.

(2) The commissioner shall, by September 1 of each year, provide the secretary with a list identifying each issuer by name and address and provide the information requested in this section.

(c) No issuer that administers Medicare coverage and federal employee programs may require that more than one form be submitted per claim in order to receive payment or reimbursement under any or all of those policies or programs.

SEC. 11. Section 10192.17 of the Insurance Code is amended to read:

10192.17. (a) Medicare supplement policies and certificates shall include a renewal, continuation, or conversion provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

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

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual

and customary," "reasonable and customary," or words of similar import.

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

(e) (1) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, and of the outline of coverage, or attached thereto, in no less than 10-point uppercase type, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate, via regular mail, within 30 days of receiving it, and to have the full premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the issuer receives the returned contract.

(3) If the issuer fails to refund all prepaid or periodic charges paid in a timely manner, then the applicant shall receive interest on the paid charges at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the issuer received the returned contract.

(f) (1) Issuers of health insurance policies, certificates, or contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the

applicant upon request, but not later than at the time the policy is delivered.

(2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

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

(1) A description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

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

(i) The notices shall not contain or be accompanied by any solicitation.

(j) (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

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

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features

of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All *Medicare supplement* plans ~~A-L~~ *authorized by federal law* shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(3) The commissioner may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(k) (1) Any disability insurance policy or certificate, a basic, catastrophic or major medical expense policy, or single premium nonrenewal policy or certificate issued to persons eligible for Medicare, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other policy identified in subdivision (b) of Section 10192.3, advertised, solicited, or issued for delivery in this state to persons eligible for Medicare, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

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

(2) Applications provided to persons eligible for Medicare for the disability insurance policies or certificates described in paragraph (1) shall disclose the extent to which the policy

duplicates Medicare in a manner required by the commissioner. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(*l*) (1) Insurers issuing Medicare supplement policies or certificates for delivery in California shall provide an outline of coverage to all applicants at the time of presentation for examination or sale as provided in Section 10605, and in no case later than at the time the application is made. Except for direct response policies, insurers shall obtain a written acknowledgment of receipt of the outline from the applicant.

Any advertisement that is not a presentation for examination or sale as defined in subdivision (e) of Section 10601 shall contain a notice in no less than 10-point uppercase type that an outline of coverage is available upon request. The insurer or agent that receives any request for an outline of coverage shall provide an outline of coverage to the person making the request within 14 days of receipt of the request.

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

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

(3) The outline of coverage shall be in the language and format prescribed in this subdivision in no less than 12-point type, and shall include the following items in the order prescribed below. Titles, as set forth below in paragraphs (B) to (H), inclusive, shall be capitalized, centered, and printed in boldface type. ~~The~~

(A) (i) The following shall only apply to policies sold for effective dates prior to June 1, 2010:

(I) The outline of coverage shall include the items, and in the same order, specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement

Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2004.

~~(A)~~

(II) The cover page shall contain the 12-plan (A-L) charts. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

"Medicare supplement insurance can be sold in only 12 standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available.

The BASIC BENEFITS included in ALL plans are:

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

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount).

Blood: First three pints of blood each year.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening."

~~[Reference to the mammogram and cervical cancer test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under 42 U.S.C. Sec. 1395ss.]~~

(ii) The following shall only apply to policies sold for effective dates on or after June 1, 2010:

(I) The outline of coverage shall include the items, and in the same order specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2008.

(II) The cover page shall contain all Medicare supplement plan charts A to D, inclusive, F, F with high deductible, G, and K to N, inclusive. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

"Medicare supplement insurance can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available. Plans E, H, I and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

The BASIC BENEFITS included in ALL plans are:

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

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening."

(B) PREMIUM INFORMATION. Premium information for plans that are offered by the insurer shall be shown on, or immediately following, the cover page and shall be clearly and prominently displayed. The premium and mode shall be stated for all offered plans. All possible premiums for the prospective applicant shall be illustrated in writing. If the premium is based on the increasing age of the insured, information specifying when and how premiums will change shall be clearly illustrated in writing. The text shall state: "We [the insurer's name] can only raise your premium if we raise the premium for all policies like yours in California."

(C) The text shall state: "Use this outline to compare benefits and premiums among policies."

(D) READ YOUR POLICY VERY CAREFULLY. The text shall state: "This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company."

(E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The text shall state: "If you find that you are not satisfied with your policy, you may return it to [insert the insurer's address]. If you send the policy back to us within 30 days after you receive it, we will treat

the policy as if it has never been issued and return all of your payments."

(F) POLICY REPLACEMENT. The text shall read: "If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it."

(G) DISCLOSURES. The text shall read: "This policy may not fully cover all of your medical costs." "Neither this company nor any of its agents are connected with Medicare." "This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult 'The Medicare Handbook' for more details." "For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California."

~~The disclosure required by this paragraph, as revised by amendments made during the 1996 portion of the 1995-96 Regular Session, shall be included in the required disclosure form no later than January 1, 1998.~~

For policies effective on dates on or after June 1, 2010, the following language shall be required until June 1, 2011, "This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale."

(H) [For policies that are not guaranteed issue] COMPLETE ANSWERS ARE IMPORTANT. The text shall read: "When you fill out the application for a new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may have the right to cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

(I) One chart for each benefit plan offered by the insurer showing the services, Medicare payments, payments under the policy and payments expected from the insured, using the same uniform format and language. No more than four plans may be

shown on one page. Include an explanation of any innovative benefits in a manner approved by the commissioner.

(m) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

SEC. 12. Section 10192.18 of the Insurance Code is amended to read:

10192.18. (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing those questions and statements may be used.

"(Statements)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.

(4) If after purchasing this policy you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

(1) (a) Did you turn 65 years of age in the last 6 months
Yes____ No____
(b) Did you enroll in Medicare Part B in the last 6 months
Yes____ No____
(c) If yes, what is the effective date _____
(2) Are you covered for medical assistance through California's Medi-Cal program
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.
Yes____ No____
If yes,
(a) Will Medi-Cal pay your premiums for this Medicare supplement policy
Yes____ No____
(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium
Yes____ No____
(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START __/__/__ END __/__/__
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy
Yes____ No____
(c) Was this your first time in this type of Medicare plan
Yes____ No____
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan
Yes____ No____
(4) (a) Do you have another Medicare supplement policy in force
Yes____ No____
(b) If so, with what company, and what plan do you have [optional for direct mailers]
Yes____ No____
(c) If so, do you intend to replace your current Medicare supplement policy with this policy

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what companies and what kind of policy

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(c) Agents shall list any other health insurance policies they have sold to the applicant as follows:

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

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

(e) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer as provided in Section 10508. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(f) The notice required by subdivision (e) for an issuer shall be in the form specified by the commissioner, using, to the extent practicable, a model notice prepared by the National Association of Insurance Commissioners for this purpose. The replacement

notice shall be printed in no less than ~~10-point~~ *12-point* type in substantially the following form:

[Insurer's name and address]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

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

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by [company name], please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT: I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage *or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan*. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

__ Additional benefits that are: _____

__ No change in benefits, but lower premiums.

__ Fewer benefits and lower premiums.

__ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

__ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:

__ Other reasons specified here: _____

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

(Signature of Agent, Broker, or Other Representative)

_____

(Signature of Applicant)

_____

(Date)

(g) No issuer, broker, agent, or other person shall cause an insured to replace a Medicare supplement insurance policy unnecessarily. In recommending replacement of any Medicare supplement insurance, an agent shall make reasonable efforts to determine the appropriateness to the potential insured.

(h) ~~Commencing January 1, 2007, an issuer shall not require or request health information from an applicant who is guaranteed issuance of any Medicare supplement coverage or require or request the applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996 during a period of guaranteed issuance of any Medicare supplement coverage and shall inform the applicant of periods of guaranteed insurance of Medicare supplement coverage. A supplementary application or other form containing those statements that the applicant and solicitor are required to sign may be used for this purpose~~ *For an individual who is subject to an open enrollment period or who is guaranteed issue as described in Section 10192.11 or 10192.12, an issuer shall not use for the purpose of determining eligibility, the applicant's*

health information, including health information acquired in compliance with the federal Health Insurance Portability and Accountability Act of 1996. A statement of this prohibition shall be included on the application form in clear and conspicuous language, in addition to the open enrollment and guaranteed issue periods described in Section 10192.11 or 10192.12. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

SEC. 13. Section 10192.20 of the Insurance Code is amended to read:

10192.20. (a) An issuer, directly or through its producers, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to ensure that excessive insurance is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the policy, the following:

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

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement policy already has health insurance and the types and amounts of that insurance.

(5) Establish auditable procedures for verifying compliance with this subdivision.

(b) In addition to the practices prohibited by this code or any other law, the following acts and practices are prohibited:

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

(2) High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase

of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising, which means making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is the solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(c) The terms "Medicare supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this article.

(d) The commissioner each year shall prepare a rate guide for Medicare supplement insurance and Medicare supplement contracts. The commissioner each year shall make the rate guide available on or before the date of the fall Medicare annual open enrollment. The rate guide shall include all of the following for each company that sells Medicare supplemental insurance or Medicare supplement contracts in California:

(1) ~~A~~ *(A) For policies sold for effective dates prior to June 1, 2010, a* listing of all the policies, plans A to L, inclusive, that are available from the company.

(B) For policies sold for effective dates on or after June 1, 2010, a listing of all the policies, plans A to D, inclusive, F, F with high deductible, G, and K to N, inclusive, that are available from the company.

(2) ~~A~~ *(A) For policies sold for effective dates prior to June 1, 2010, a* listing of all the policies, plans A to L, inclusive, for Medicare beneficiaries under the age of 65 that are available from the company.

(B) For policies sold for effective dates on or after June 1, 2010, a listing of all the policies, plans, A to D, inclusive, F, F with high deductible, G, and K to N, inclusive, for Medicare beneficiaries under the age 65 that are available from the company.

(3) The toll-free telephone number of the company that consumers can use to obtain information from the company.

(4) Sample rates for each policy listed pursuant to paragraphs (1) and (2). The sample rates shall be for ages 0-65, 65, 70, 75, and 80.

(5) The premium rate methodology for each policy listed pursuant to paragraphs (1) and (2). "Premium rate methodology" means attained age, issue age, or community rated.

(6) The waiting period for preexisting conditions for each policy listed pursuant to paragraphs (1) and (2).

(e) The consumer rate guide prepared pursuant to subdivision (d) shall be distributed using all of the following methods:

(1) Through Health Insurance Counseling and Advocacy Program (HICAP) offices.

(2) By telephone, using the department's consumer toll-free telephone number.

(3) On the department's Internet Web site.

(4) In addition to the distribution methods described in paragraphs (1) to (3), inclusive, each insurer that markets Medicare supplement insurance or Medicare supplement contracts in this state shall provide on the application form a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov)."

SEC. 14. Section 10192.24 is added to the Insurance Code, to read:

10192.24. This section applies to all policies with policy years beginning on or after May 21, 2009.

(a) In addition to the requirements set forth under Sections 10140 and 10143, an issuer of a Medicare supplement policy or certificate shall adhere to the requirements imposed by the federal Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233) as follows:

(1) The issuer shall not deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to that individual or a family member of the individual.

(2) The issuer shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an

individual on the basis of the genetic information with respect to that individual or a family member of the individual.

(b) Nothing in subdivision (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, to do either of the following:

(1) Deny or condition the issuance or effectiveness of the policy or certificate or increase the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

(2) Increase 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. For purposes of this paragraph, the manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the premium for the group.

(c) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of that individual to undergo a genetic test.

(d) Subdivision (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subdivision (a).

(e) For purposes of carrying out subdivision (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(f) An issuer of a Medicare supplement policy or certificate shall not request, require, seek, or purchase genetic information for underwriting purposes.

(g) An issuer of a Medicare supplement policy or certificate shall not request, require, seek, or purchase genetic information with respect to any individual or a family member of that individual prior to the individual's enrollment under the policy in connection with that enrollment.

(h) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual or

a family member of that individual, the request, requirement, or purchase shall not be considered a violation of subdivision (g) if the request, requirement, or purchase is not in violation of subdivision (f). However, the issuer shall not use any genetic information obtained under this section for any prohibited purpose described in this section or in Sections 10140 and 10143.

(i) For the purposes of this section, the following definitions shall apply:

(1) "Issuer of a Medicare supplement policy or certificate" includes a third-party administrator, or other person acting for or on behalf of an issuer.

(2) "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 the individual.

(3) "Genetic information" means, with respect to any individual, information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. The term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by that pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic education, or genetic counseling, including obtaining, interpreting, or assessing genetic information.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or 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.

(6) "Underwriting purposes" includes all of the following:

(A) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the policy.

(B) The computation of premium or contribution amounts under the policy.

(C) The application of any preexisting condition exclusion under the policy.

(D) Other activities related to the creation, renewal, or replacement of a policy of health insurance or health benefits.

SEC. 15. It is the intent of the Legislature to enact legislation that would make the changes required by the federal Medicare Improvements for Patients and Providers Act of 2008 and the federal Genetic Information Nondiscrimination Act of 2008 to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 16. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the changes required by the federal Medicare Improvements for Patients and Providers Act of 2008 and the federal Genetic Information Nondiscrimination Act of 2008 by the dates imposed under those acts, it is necessary that this act take effect immediately.

O