

AMENDED IN ASSEMBLY MAY 6, 2009

AMENDED IN ASSEMBLY APRIL 20, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

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 1358.4, 1358.6, 1358.8, 1358.9, 1358.11, 1358.12, 1358.13, 1358.17, 1358.18, and 1358.20 of, and to add Sections 1350.1, 1358.81, 1358.91, and 1358.24 to, the Health and Safety Code, and 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 amended, Committee on Health. Medicare supplement coverage: Medicare advantage.

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.

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.

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.

With respect to *plans and* health insurers that issue Medicare supplement policies, this bill would also require that the employer no longer provide the individual with insurance that covers all of the payment for the 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 (*HIPAA*).

With respect to *plans and* health insurers that issue Medicare supplement policies, this bill would instead prohibit an issuer from *requiring or* using the applicant's health information for the purpose of determining eligibility for coverage *or premium levels, or as otherwise specified, and would require notice of that prohibition to be included on application forms. The bill would require an issuer that requests an applicant to provide health information to obtain authorization pursuant to the disclosure requirements under HIPAA.*

Existing law provides for the federal Medicare Program, which provides health care benefits, including prescription drug benefits, to persons 65 years of age ~~and~~ or older and other specified persons. Existing law establishes the Medicare Advantage program, which allows beneficiaries of the Medicare Program to enroll in private health plans to receive Medicare-covered benefits.

This bill would require a health care service plan that arranges to provide health care services in this state pursuant to the Medicare Advantage program to be licensed under the Knox-Keene Act and to comply with all requirements under that act except to the extent preempted by federal law. The bill would require that any other arrangement for health care services comply with the act to the extent applicable.

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

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This bill would make other conforming, technical, and related changes.

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

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

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

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

- 1 SECTION 1. Section 1350.1 is added to the Health and Safety
- 2 Code, to read:
- 3 1350.1. (a) A health care service plan that arranges directly
- 4 or indirectly to provide health care services in this state under the
- 5 Medicare Advantage program pursuant to Part C (commencing
- 6 with Section 1395w-21) of Title XVIII of Chapter 7 of Title 42 of
- 7 the United States Code shall be licensed under this chapter and
- 8 shall comply with all requirements under this chapter except to
- 9 the extent preempted by federal law.

(b) Any arrangement for health care services other than that specified in subdivision (a) shall comply with all of the requirements of this chapter to the extent applicable.

SEC. 2. Section 1358.4 of the Health and Safety Code is amended to read:

1358.4. The following definitions apply for the purposes of this article:

(a) "Applicant" means:

(1) An individual enrollee who seeks to contract for health coverage, in the case of an individual Medicare supplement contract.

(2) An enrollee who seeks to obtain health coverage through a group, in the case of a group Medicare supplement contract.

(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) "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.

(d) (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), 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.

1 (F) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

22 (D) Workers' compensation or similar insurance.

23 (E) Automobile medical payment insurance.

24 (F) Credit-only insurance.

25 (G) Coverage for onsite medical clinics.

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

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

32 (A) Limited scope dental or vision benefits.

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

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

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

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

40 (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:

(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.

(e) “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).

(f) “Insolvency” means when an issuer, licensed to transact the business of a health care service plan 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.

(g) “Issuer” means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Division 2 of the Insurance Code.

(h) “Medicare” means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) “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.

(j) “Medicare supplement contract” means a group or individual plan contract of hospital and medical service associations or health care service plans, other than a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C.A. Section 1395mm) or an issued contract under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or

1 designed primarily as a supplement to reimbursements under
2 Medicare for the hospital, medical, or surgical expenses of persons
3 eligible for Medicare. “Contract” means “Medicare supplement
4 contract,” unless the context requires otherwise. “Medicare
5 supplement contract” does not include a Medicare Advantage plan
6 established under Medicare Part C, an outpatient prescription drug
7 plan established under Medicare Part D, or a health care
8 prepayment plan that provides benefits pursuant to an agreement
9 under subparagraph (A) of paragraph (1) of subsection (a) of
10 Section 1833 of the Social Security Act.

11 (k) “Prestandardized Medicare supplement benefit plan,”
12 “prestandardized benefit plan,” or “prestandardized plan” means
13 a group or individual Medicare supplement contract issued prior
14 to July 21, 1992.

15 (l) “1990 standardized Medicare supplement benefit plan,”
16 “1990 standardized benefit plan,” or “1990 plan” means a group
17 or individual Medicare supplement contract issued on or after July
18 21, 1992, and with an effective date prior to June 1, 2010, and
19 includes Medicare supplement contracts renewed on or after that
20 date ~~which~~ *that* are not replaced by the issuer at the request of the
21 enrollee or subscriber.

22 (m) “2010 standardized Medicare supplement benefit plan,”
23 “2010 standardized benefit plan,” or “2010 plan” means a group
24 or individual Medicare supplement contract issued with an effective
25 date on or after June 1, 2010.

26 (n) “Secretary” means the Secretary of the United States
27 Department of Health and Human Services.

28 SEC. 3. Section 1358.6 of the Health and Safety Code is
29 amended to read:

30 1358.6. (a) (1) Except for permitted preexisting condition
31 clauses as described in Sections 1358.7, 1358.8, and 1358.81, a
32 contract shall not be advertised, solicited, or issued for delivery
33 as a Medicare supplement contract if the contract contains
34 definitions, limitations, exclusions, conditions, reductions, or other
35 provisions that are more restrictive or limiting than that term as
36 officially used in Medicare, except as expressly authorized by this
37 article.

38 (2) No issuer may advertise, solicit, or issue for delivery any
39 Medicare supplement contract with hospital or medical coverage

1 if the contract contains any of the prohibited provisions described
2 in subdivision (b).

3 (b) The following provisions shall be deemed to be unfair,
4 unreasonable, and inconsistent with the objectives of this chapter
5 and shall not be contained in any Medicare supplement contract:

6 (1) Any waiver, exclusion, limitation, or reduction based on or
7 relating to a preexisting disease or physical condition, unless that
8 waiver, exclusion, limitation, or reduction (A) applies only to
9 coverage for specified services rendered not more than six months
10 from the effective date of coverage, (B) is based on or relates only
11 to a preexisting disease or physical condition defined no more
12 restrictively than a condition for which medical advice was given
13 or treatment was recommended by or received from a physician
14 within six months before the effective date of coverage, (C) does
15 not apply to any coverage under any group contract, and (D) is
16 approved in advance by the director. Any limitations with respect
17 to a preexisting condition shall appear as a separate paragraph of
18 the contract and be labeled "Preexisting Condition Limitations."

19 (2) Except with respect to a group contract subject to, and in
20 compliance with, Section 1399.62, any provision denying coverage,
21 after termination of the contract, for services provided continuously
22 beginning while the contract was in effect, during the continuous
23 total disability of the subscriber or enrollee, except that the
24 coverage may be limited to a reasonable period of time not less
25 than the duration of the contract benefit period, if any, and may
26 be limited to the maximum benefits provided under the contract.

27 (c) A Medicare supplement contract in force shall not contain
28 benefits that duplicate benefits provided by Medicare.

29 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of
30 Section 1358.8, a Medicare supplement contract with benefits for
31 outpatient prescription drugs that was issued prior to January 1,
32 2006, shall be renewed for current enrollees and subscribers, at
33 their option, who do not enroll in Medicare Part D.

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

36 (3) On and after January 1, 2006, a Medicare supplement
37 contract with benefits for outpatient prescription drugs shall not
38 be renewed after the enrollee or subscriber enrolls in Medicare
39 Part D unless both of the following conditions exist:

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

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

8 SEC. 4. Section 1358.8 of the Health and Safety Code is
9 amended to read:

10 1358.8. The following standards are applicable to all Medicare
11 supplement contracts advertised, solicited, or issued for delivery
12 on or after January 1, 2001, and with an effective date prior to June
13 1, 2010. A contract shall not be advertised, solicited, or issued for
14 delivery as a Medicare supplement contract unless it complies with
15 these benefit standards.

16 (a) The following general standards apply to Medicare
17 supplement contracts and are in addition to all other requirements
18 of this article:

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

26 (2) A Medicare supplement contract shall not indemnify against
27 losses resulting from sickness on a different basis than losses
28 resulting from accidents.

29 (3) A Medicare supplement contract shall provide that benefits
30 designed to cover cost-sharing amounts under Medicare will be
31 changed automatically to coincide with any changes in the
32 applicable Medicare deductible, copayment, or coinsurance
33 amounts. Prepaid or periodic charges may be modified to
34 correspond with those changes.

35 (4) A Medicare supplement contract shall not provide for
36 termination of coverage of a spouse solely because of the
37 occurrence of an event specified for termination of coverage of
38 the covered person, other than the nonpayment of the prepaid or
39 periodic charge.

1 (5) Each Medicare supplement contract shall be guaranteed
2 renewable.

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

5 (B) The issuer shall not cancel or nonrenew the contract for any
6 reason other than nonpayment of the prepaid or periodic charge
7 or misrepresentation of the risk by the applicant that is shown by
8 the plan to be material to the acceptance for coverage. The
9 contestability period for Medicare supplement contracts shall be
10 two years.

11 (C) If a group Medicare supplement contract is terminated by
12 the subscriber and is not replaced as provided under subparagraph
13 (E), the issuer shall offer enrollees an individual Medicare
14 supplement contract that, at the option of the enrollee, either
15 provides for continuation of the benefits contained in the terminated
16 contract or provides for benefits that otherwise meet the
17 requirements of this subsection.

18 (D) If an individual is an enrollee in a group Medicare
19 supplement contract and the individual membership in the group
20 is terminated, the issuer shall either offer the enrollee the
21 conversion opportunity described in subparagraph (C) or, at the
22 option of the subscriber, shall offer the enrollee continuation of
23 coverage under the group contract.

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

31 (F) If a Medicare supplement contract eliminates an outpatient
32 prescription drug benefit as a result of requirements imposed by
33 the Medicare Prescription Drug, Improvement, and Modernization
34 Act of 2003 (Public Law 108-173), the contract as modified as a
35 result of that act shall be deemed to satisfy the guaranteed renewal
36 requirements of this paragraph.

37 (6) Termination of a Medicare supplement contract shall be
38 without prejudice to any continuous loss that commenced while
39 the contract was in force, but the extension of benefits beyond the
40 period during which the contract was in force may be predicated

1 upon the continuous total disability of the covered person, limited
2 to the duration of the contract benefit period, if any, or to payment
3 of the maximum benefits. Receipt of Medicare Part D benefits
4 shall not be considered in determining a continuous loss.

5 (7) (A) (i) A Medicare supplement contract shall provide that
6 benefits and prepaid or periodic charges under the contract shall
7 be suspended at the request of the enrollee for the period, not to
8 exceed 24 months, in which the enrollee has applied for and is
9 determined to be entitled to medical assistance under Title XIX
10 of the federal Social Security Act, but only if the enrollee notifies
11 the issuer of the contract within 90 days after the date the individual
12 becomes entitled to assistance.

13 If suspension occurs and if the enrollee loses entitlement to
14 medical assistance, the contract shall be automatically reinstituted,
15 effective as of the date of termination of entitlement, as of the
16 termination of entitlement if the enrollee provides notice of loss
17 of entitlement within 90 days after the date of loss and pays the
18 prepaid or periodic charge attributable to the period, effective as
19 of the date of termination of entitlement. Upon receipt of timely
20 notice, the issuer shall return directly to the enrollee that portion
21 of the prepaid or periodic charge attributable to the period the
22 enrollee was entitled to medical assistance, subject to adjustment
23 for paid claims.

24 (ii) A Medicare supplement contract shall provide that benefits
25 and premiums under the contract shall be suspended at the request
26 of the enrollee or subscriber for any period that may be provided
27 by federal regulation if the enrollee or subscriber is entitled to
28 benefits under Section 226 (b) of the Social Security Act and is
29 covered under a group health plan, as defined in Section 1862
30 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and
31 the enrollee or subscriber loses coverage under the group health
32 plan, the contract shall be automatically reinstituted, effective as
33 of the date of loss of coverage if the enrollee or subscriber provides
34 notice within 90 days of the date of the loss of coverage.

35 (B) Reinstitution of coverages:

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

38 (ii) Shall provide for resumption of coverage that is substantially
39 equivalent to coverage in effect before the date of suspension. If
40 the suspended Medicare supplement contract provided coverage

1 for outpatient prescription drugs, reinstatement of the contract for
2 a Medicare Part D enrollee shall not include coverage for outpatient
3 prescription drugs but shall otherwise provide coverage that is
4 substantially equivalent to the coverage in effect before the date
5 of suspension.

6 (iii) Shall provide for classification of prepaid or periodic
7 charges on terms at least as favorable to the enrollee as the prepaid
8 or periodic charge classification terms that would have applied to
9 the enrollee had the coverage not been suspended.

10 (8) If an issuer makes a written offer to the Medicare supplement
11 enrollee or subscriber of one or more of its plan contracts, to
12 exchange during a specified period from his or her 1990
13 standardized plan, as described in Section 1358.9, to a 2010
14 standardized plan, as described in Section 1358.91, the offer and
15 subsequent exchange shall comply with the following requirements:

16 (A) An issuer need not provide justification to the director if
17 the enrollee or subscriber replaces a 1990 standardized plan
18 contract with an issue age rated 2010 standardized plan contract
19 at the enrollee or subscriber's original issue age and duration. If
20 an enrollee or subscriber's plan contract to be replaced is priced
21 on an issue age rate schedule at the time of ~~such~~ *that* offer, the rate
22 charged to the enrollee or subscriber for the new exchanged plan
23 shall recognize the plan contract reserve buildup, due to the
24 prefunding inherent in the use of an issue age rate basis, for the
25 benefit of the enrollee or subscriber. The method proposed to be
26 used by an issuer shall be filed with the director.

27 (B) The rating class of the new plan contract shall be the class
28 closest to the enrollee or subscriber's class of the replaced
29 coverage.

30 (C) An issuer may not apply new preexisting condition
31 limitations or a new incontestability period to the new plan contract
32 for those benefits contained in the exchanged 1990 standardized
33 plan contract of the enrollee or subscriber, but may apply
34 preexisting condition limitations of no more than six months to
35 any added benefits contained in the new 2010 standardized plan
36 contract not contained in the exchanged plan contract. This
37 subdivision shall not apply to an applicant who is guaranteed issue
38 under Section 1358.11 or 1358.12.

1 (D) The new plan contract shall be offered to all enrollees or
2 subscribers within a given plan, except where the offer or issue
3 would be in violation of state or federal law.

4 (9) A Medicare supplement contract shall not be limited to
5 coverage for a single disease or affliction.

6 (10) A Medicare supplement contract shall provide an
7 examination period of 30 days after the receipt of the contract by
8 the applicant for purposes of review, during which time the
9 applicant may return the contract as described in subdivision (e)
10 of Section 1358.17.

11 (11) A Medicare supplement contract shall additionally meet
12 any other minimum benefit standards as established by the director.

13 (12) Within 30 days prior to the effective date of any Medicare
14 benefit changes, an issuer shall file with the director, and notify
15 its subscribers and enrollees of, modifications it has made to
16 Medicare supplement contracts.

17 (A) The notice shall include a description of revisions to the
18 Medicare Program and a description of each modification made
19 to the coverage provided under the Medicare supplement contract.

20 (B) The notice shall inform each subscriber and enrollee as to
21 when any adjustment in the prepaid or periodic charges will be
22 made due to changes in Medicare benefits.

23 (C) The notice of benefit modifications and any adjustments to
24 the prepaid or periodic charges shall be in outline form and in clear
25 and simple terms so as to facilitate comprehension. The notice
26 shall not contain or be accompanied by any solicitation.

27 (13) No modifications to existing Medicare supplement coverage
28 shall be made at the time of, or in connection with, the notice
29 requirements of this article except to the extent necessary to
30 eliminate duplication of Medicare benefits and any modifications
31 necessary under the contract to provide indexed benefit adjustment.

32 (b) With respect to the standards for basic (core) benefits for
33 benefit plans A to J, inclusive, every issuer shall make available
34 a contract including only the following basic “core” package of
35 benefits to each prospective applicant. This “core” package of
36 benefits shall be referred to as standardized Medicare supplement
37 benefit plan “A”. An issuer may make available to prospective
38 applicants any of the other Medicare supplement benefit plans in
39 addition to the basic core package, but not in lieu of ~~it~~ *that package*.

1 (1) Coverage of Part A Medicare eligible expenses for
2 hospitalization to the extent not covered by Medicare from the
3 61st day to the 90th day, inclusive, in any Medicare benefit period.

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

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

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

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

23 (c) The following additional benefits shall be included in
24 Medicare supplement benefit plans B to J, inclusive, only as
25 provided by Section 1358.9.

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

29 (2) With respect to skilled nursing facility care, coverage for
30 the actual billed charges up to the coinsurance amount from the
31 21st day to the 100th day, inclusive, in a Medicare benefit period
32 for posthospital skilled nursing facility care eligible under Medicare
33 Part A.

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

37 (4) With respect to 80 percent of the Medicare Part B excess
38 charges, coverage for 80 percent of the difference between the
39 actual Medicare Part B charge as billed, not to exceed any charge

1 limitation established by the Medicare Program or state law, and
2 the Medicare-approved Part B charge.

3 (5) With respect to 100 percent of the Medicare Part B excess
4 charges, coverage for all of the difference between the actual
5 Medicare Part B charge as billed, not to exceed any charge
6 limitation established by the Medicare Program or state law, and
7 the Medicare-approved Part B charge.

8 (6) With respect to the basic outpatient prescription drug benefit,
9 coverage for 50 percent of outpatient prescription drug charges,
10 after a two-hundred-fifty-dollar (\$250) calendar year deductible,
11 to a maximum of one thousand two hundred fifty dollars (\$1,250)
12 in benefits received by the insured per calendar year, to the extent
13 not covered by Medicare. On and after January 1, 2006, no
14 Medicare supplement contract may be sold or issued if it includes
15 a prescription drug benefit.

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

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

36 (9) With respect to the preventive medical care benefit, coverage
37 for the following preventive health services:

38 (A) An annual clinical preventive medical history and physical
39 examination that may include tests and services from subparagraph

1 (B) and patient education to address preventive health care
2 measures.

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

7 (i) Fecal occult blood test.

8 (ii) Mammogram.

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

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

18 (10) With respect to the at-home recovery benefit, coverage for
19 services to provide short-term, at-home assistance with activities
20 of daily living for those recovering from an illness, injury, or
21 surgery.

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

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

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

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

37 (iv) "At-home recovery visit" means the period of a visit
38 required to provide at-home recovery care, without any limit on
39 the duration of the visit, except that each consecutive four hours

1 in a 24-hour period of services provided by a care provider is one
2 visit.

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

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

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

11 (iii) Coverage is limited to the following:

12 (I) No more than the number and type of at-home recovery visits
13 certified as necessary by the covered person's attending physician.
14 The total number of at-home recovery visits shall not exceed the
15 number of Medicare-approved home health care visits under a
16 Medicare-approved home care plan of treatment.

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

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

21 (IV) Seven visits in any one week.

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

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

25 (VII) At-home recovery visits while the covered person is
26 covered under the contract and not otherwise excluded.

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

31 (C) Coverage is excluded for the following:

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

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

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

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

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

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

13 (4) With respect to the Medicare Part A deductible, coverage
14 for 50 percent of the Medicare Part A inpatient hospital deductible
15 amount per benefit period until the out-of-pocket limitation
16 described in paragraph (10) is met.

17 (5) With respect to skilled nursing facility care, coverage for
18 50 percent of the coinsurance amount for each day used from the
19 21st day to the 100th day, inclusive, in a Medicare benefit period
20 for posthospital skilled nursing facility care eligible under Medicare
21 Part A until the out-of-pocket limitation described in paragraph
22 (10) is met.

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

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

33 (8) Except for coverage provided in paragraph (9), coverage for
34 50 percent of the cost sharing otherwise applicable under Medicare
35 Part B after the enrollee or subscriber pays the Part B deductible,
36 until the out-of-pocket limitation is met as described in paragraph
37 (10).

38 (9) Coverage of 100 percent of the cost sharing for Medicare
39 Part B preventive services, after the enrollee or subscriber pays
40 the Medicare Part B deductible.

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

7 (e) The standardized Medicare supplement benefit plan “L”
8 shall consist of the following benefits:

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

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

15 (3) With respect to skilled nursing facility care, coverage for
16 75 percent of the coinsurance amount for each day used from the
17 21st day to the 100th day, inclusive, in a Medicare benefit period
18 for posthospital skilled nursing facility care eligible under Medicare
19 Part A until the out-of-pocket limitation described in paragraph
20 (8) is met.

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

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

29 (6) Except for coverage provided in paragraph (7), coverage for
30 75 percent of the cost sharing otherwise applicable under Medicare
31 Part B after the enrollee or subscriber pays the Part B deductible
32 until the out-of-pocket limitation described in paragraph (8) is met.

33 (7) Coverage for 100 percent of the cost sharing for Medicare
34 Part B preventive services after the enrollee or subscriber pays the
35 Part B deductible.

36 (8) Coverage of 100 percent of the cost sharing for Medicare
37 Parts A and B for the balance of the calendar year after the
38 individual has reached the out-of-pocket limitation on annual
39 expenditures under Medicare Parts A and B of two thousand dollars

1 (\$2,000) in 2006, indexed each year by the appropriate inflation
2 adjustment specified by the secretary.

3 (f) A contract shall not contain any provision delaying the
4 effective date of coverage beyond the first day of the month
5 following the date of receipt by the issuer of the applicant's
6 properly completed application, except that the effective date of
7 coverage may be delayed until the 65th birthday of an applicant
8 who is to become eligible for Medicare by reason of age if the
9 application is received any time during the three months
10 immediately preceding the applicant's 65th birthday.

11 SEC. 5. Section 1358.81 is added to the Health and Safety
12 Code, to read:

13 1358.81. The following standards are applicable to all Medicare
14 supplement contracts delivered or issued for delivery in this state
15 with an effective date on or after June 1, 2010. No contract may
16 be advertised, solicited, delivered, or issued for delivery in this
17 state as a Medicare supplement contract unless it complies with
18 these benefit standards. No issuer may offer any 1990 standardized
19 Medicare supplement contract for sale with an effective date on
20 or after June 1, 2010. Benefit standards applicable to Medicare
21 supplement contracts issued with an effective date before June 1,
22 2010, remain subject to the requirements of Section 1358.8.

23 (a) The following general standards apply to Medicare
24 supplement contracts and are in addition to all other requirements
25 of this article.

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

33 (2) A Medicare supplement contract shall not indemnify against
34 losses resulting from sickness on a different basis than losses
35 resulting from accidents.

36 (3) A Medicare supplement contract shall provide that benefits
37 designed to cover cost-sharing amounts under Medicare will be
38 changed automatically to coincide with any changes in the
39 applicable Medicare deductible, copayment, or coinsurance

1 amounts. Prepaid or periodic charges may be modified to
2 correspond with those changes.

3 (4) A Medicare supplement contract shall not provide for
4 termination of coverage of a spouse solely because of the
5 occurrence of an event specified for termination of coverage of
6 the enrollee or subscriber, other than the nonpayment of prepaid
7 or periodic charges.

8 (5) Each Medicare supplement contract shall be guaranteed
9 renewable.

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

12 (B) The issuer shall not cancel or nonrenew the contract for any
13 reason other than nonpayment of prepaid or periodic charges or
14 material misrepresentation.

15 (C) If the Medicare supplement contract is terminated by the
16 master policyholder and is not replaced as provided under
17 subparagraph (E), the issuer shall offer enrollees or subscribers an
18 individual Medicare supplement contract which, at the option of
19 the enrollee or subscriber, does one of the following:

20 (i) Provides for continuation of the benefits contained in the
21 group contract.

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

24 (D) If an individual is an enrollee or subscriber in a group
25 Medicare supplement contract and the individual terminates
26 membership in the group, the issuer shall do one of the following:

27 (i) Offer the enrollee or subscriber the conversion opportunity
28 described in subparagraph (C).

29 (ii) At the option of the ~~group contract holder~~ *contractholder*,
30 offer the enrollee or subscriber continuation of coverage under the
31 group contract.

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

39 (ii) If a Medicare supplement contract replaces another Medicare
40 supplement contract that has been in force for six months or more,

1 the replacing issuer shall not impose an exclusion or limitation
2 based on a preexisting condition. If the original coverage has been
3 in force for less than six months, the replacing issuer shall waive
4 any time period applicable to preexisting conditions, waiting
5 periods, elimination periods, or probationary periods in the new
6 contract to the extent the time was spent under the original
7 coverage.

8 (6) Termination of a Medicare supplement contract shall be
9 without prejudice to any continuous loss ~~which~~ *that* commenced
10 while the contract was in force, but the extension of benefits
11 beyond the period during which the contract was in force may be
12 predicated upon the continuous total disability of the enrollee or
13 subscriber, limited to the duration of the contract benefit period,
14 if any, or payment of the maximum benefits. Receipt of Medicare
15 Part D benefits shall not be considered in determining a continuous
16 loss.

17 (7) (A) (i) A Medicare supplement contract shall provide that
18 benefits and prepaid or periodic charges under the contract shall
19 be suspended at the request of the enrollee or subscriber for the
20 period, not to exceed 24 months, in which the enrollee or subscriber
21 has applied for, and is determined to be entitled to, medical
22 assistance under Medi-Cal under Title XIX of the federal Social
23 Security Act, but only if the enrollee or subscriber notifies the
24 issuer of the contract within 90 days after the date the individual
25 becomes entitled to assistance. Upon receipt of timely notice, the
26 insurer shall return directly to the enrollee or subscriber that portion
27 of the prepaid or periodic charge attributable to the period of
28 Medi-Cal eligibility, subject to adjustment for paid claims.

29 (ii) If suspension occurs and if the enrollee or subscriber loses
30 entitlement to medical assistance under Medi-Cal, the Medicare
31 supplement contract shall be automatically reinstituted, effective
32 as of the date of termination of entitlement, as of the termination
33 of entitlement if the enrollee or subscriber provides notice of loss
34 of entitlement within 90 days after the date of loss and pays the
35 prepaid or periodic charge attributable to the period, effective as
36 of the date of termination of entitlement or equivalent coverage
37 shall be provided if the prior contract is no longer available.

38 (iii) Each Medicare supplement contract shall provide that
39 benefits and prepaid or periodic charges under the contract shall
40 be suspended (for any period that may be provided by federal

regulation) at the request of the enrollee or subscriber if the enrollee or subscriber 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 enrollee or subscriber loses coverage under the group health plan, the contract shall be automatically reinstituted (effective as of the date of loss of coverage) if the enrollee or subscriber provides notice of loss of coverage within 90 days after the date of the loss and pays the applicable prepaid or periodic charge.

(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 prepaid or periodic charges on terms at least as favorable to the enrollee or subscriber as the classification of the prepaid or periodic charge that would have applied to the enrollee or subscriber had the coverage not been suspended.

(b) With respect to the standards for basic (core) benefits for benefit plans A, B, C, D, F, F with high deductible, G, M, and N, every issuer of Medicare supplement benefit plans shall make available a contract including only the following basic “core” package of benefits to each prospective enrollee or subscriber. An issuer may make available to prospective enrollees or subscribers any of the other Medicare supplement benefit plans in addition to the basic core package, but not in lieu of ~~it~~ *that package*.

(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

1 appropriate Medicare standard of payment, subject to a lifetime
2 maximum benefit of an additional 365 days. The provider shall
3 accept the issuer's payment as payment in full and may not bill
4 the insured for any balance.

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

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

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

16 (c) The following additional benefits shall be included in
17 Medicare supplement benefit plans B, C, D, F, F with high
18 deductible, G, M, and N, as provided in Section 1358.91:

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

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

25 (3) With respect to skilled nursing facility care, coverage for
26 the actual billed charges up to the coinsurance amount from the
27 21st day through the 100th day in a Medicare benefit period for
28 posthospital skilled nursing facility care eligible under Medicare
29 Part A.

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

33 (5) With respect to 100 percent of the Medicare Part B excess
34 charges, coverage for all of the difference between the actual
35 Medicare Part B charges as billed, not to exceed any charge
36 limitation established by the Medicare program or state law, and
37 the Medicare-approved Part B charge.

38 (6) With respect to medically necessary emergency care in a
39 foreign country, coverage to the extent not covered by Medicare
40 for 80 percent of the billed charges for Medicare-eligible expenses

1 for medically necessary emergency hospital, physician, and medical
2 care received in a foreign country, which care would have been
3 covered by Medicare if provided in the United States and which
4 care began during the first 60 consecutive days of each trip outside
5 the United States, subject to a calendar year deductible of two
6 hundred fifty dollars (\$250), and a lifetime maximum benefit of
7 fifty thousand dollars (\$50,000). For purposes of this benefit,
8 “emergency care” shall mean care needed immediately because
9 of an injury or an illness of sudden and unexpected onset.

10 SEC. 6. Section 1358.9 of the Health and Safety Code is
11 amended to read:

12 1358.9. The following standards are applicable to all Medicare
13 supplement contracts delivered or issued for delivery in this state
14 on or after July 21, 1992, and with an effective date prior to June
15 1, 2010.

16 (a) An issuer shall make available to each prospective enrollee
17 a contract form containing only the basic (core) benefits, as defined
18 in subdivision (b) of Section 1358.8.

19 (b) No groups, packages, or combinations of Medicare
20 supplement benefits other than those listed in this section shall be
21 offered for sale in this state, except as may be permitted by
22 subdivision (f) and by Section 1358.10.

23 (c) Benefit plans shall be uniform in structure, language,
24 designation and format to the standard benefit plans A to J,
25 inclusive, listed in subdivision (e), and shall conform to the
26 definitions in Section 1358.4. Each benefit shall be structured in
27 accordance with the format provided in subdivisions (b), (c), (d),
28 and (e) of Section 1358.8 and list the benefits in the order listed
29 in subdivision (e). For purposes of this section, “structure,
30 language, and format” means style, arrangement, and overall
31 content of a benefit.

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

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

37 (1) Standardized Medicare supplement benefit plan A shall be
38 limited to the basic (core) benefit common to all benefit plans, as
39 defined in subdivision (b) of Section 1358.8.

1 (2) Standardized Medicare supplement benefit plan B shall
2 include only the following: the core benefit, plus the Medicare
3 Part A deductible as defined in paragraph (1) of subdivision (c) of
4 Section 1358.8.

5 (3) Standardized Medicare supplement benefit plan C shall
6 include only the following: the core benefit, plus the Medicare
7 Part A deductible, skilled nursing facility care, Medicare Part B
8 deductible, and medically necessary emergency care in a foreign
9 country as defined in paragraphs (1), (2), (3), and (8) of subdivision
10 (c) of Section 1358.8, respectively.

11 (4) Standardized Medicare supplement benefit plan D shall
12 include only the following: the core benefit, plus the Medicare
13 Part A deductible, skilled nursing facility care, medically necessary
14 emergency care in a foreign country, and the at-home recovery
15 benefit as defined in paragraphs (1), (2), (8), and (10) of
16 subdivision (c) of Section 1358.8, respectively.

17 (5) Standardized Medicare supplement benefit plan E shall
18 include only the following: the core benefit, plus the Medicare
19 Part A deductible, skilled nursing facility care, medically necessary
20 emergency care in a foreign country, and preventive medical care
21 as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of
22 Section 1358.8, respectively.

23 (6) Standardized Medicare supplement benefit plan F shall
24 include only the following: the core benefit, plus the Medicare
25 Part A deductible, the skilled nursing facility care, the Medicare
26 Part B deductible, 100 percent of the Medicare Part B excess
27 charges, and medically necessary emergency care in a foreign
28 country as defined in paragraphs (1), (2), (3), (5), and (8) of
29 subdivision (c) of Section 1358.8, respectively.

30 (7) Standardized Medicare supplement benefit high deductible
31 plan F shall include only the following: 100 percent of covered
32 expenses following the payment of the annual high deductible plan
33 F deductible. The covered expenses include the core benefit, plus
34 the Medicare Part A deductible, skilled nursing facility care, the
35 Medicare Part B deductible, 100 percent of the Medicare Part B
36 excess charges, and medically necessary emergency care in a
37 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
38 of subdivision (c) of Section 1358.8, respectively. The annual high
39 deductible plan F deductible shall consist of out-of-pocket
40 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 1358.8, 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 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract 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 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract 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 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract 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 1358.8, 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 contract 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 1358.8.

(14) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in subdivision (e) of Section 1358.8.

(f) An issuer may, with the prior approval of the director, offer contracts with new or innovative benefits in addition to the benefits provided in a contract that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement contracts, that are not otherwise available and that are cost-effective and offered in a manner that is consistent with the goal of simplification of

1 Medicare supplement contracts. On and after January 1, 2006, the
2 innovative benefit shall not include an outpatient prescription drug
3 benefit.

4 SEC. 7. Section 1358.91 is added to the Health and Safety
5 Code, to read:

6 1358.91. The following standards are applicable to all Medicare
7 supplement contracts delivered or issued for delivery in this state
8 with an effective date on or after June 1, 2010. No contract may
9 be advertised, solicited, delivered, or issued for delivery in this
10 state as a Medicare supplement contract unless it complies with
11 these benefit plan standards. Benefit plan standards applicable to
12 Medicare supplement contracts issued with an effective date before
13 June 1, 2010, remain subject to the requirements of Section 1358.9.

14 (a) (1) An issuer shall make available to each prospective
15 enrollee and subscriber a contract containing only the basic (core)
16 benefits, as defined in subdivision (b) of Section 1358.81.

17 (2) If an issuer makes available any of the additional benefits
18 described in subdivision (c) of Section 1358.81, or offers
19 standardized benefit plans *plan K* or *L*, as described in paragraphs
20 (8) and (9) of subdivision (e), then the issuer shall make available
21 to each prospective enrollee and subscriber, in addition to a contract
22 with only the basic (core) benefits as described in paragraph (1),
23 a contract containing either standardized benefit plan C, as
24 described in paragraph (3) of subdivision (e), or standardized
25 benefit plan F, as described in paragraph (5) of subdivision (e).

26 (b) No groups, packages or combinations of Medicare
27 supplement benefits other than those listed in this section shall be
28 offered for sale in this state, except as may be permitted in
29 subdivision (f) and by Section 1358.10.

30 (c) Benefit plans shall be uniform in structure, language,
31 designation, and format to the standard benefit plans listed in
32 subdivision (e) and conform to the definitions in Section 1358.4.
33 Each benefit shall be structured in accordance with the format
34 provided in subdivisions (b) and (c) of Section 1358.81; or, in the
35 case of ~~plans~~ *plan K* or *L*, in paragraphs (8) or (9) of subdivision
36 (e) of Section 1358.91 and list the benefits in the order shown in
37 subdivision (e). For purposes of this section, “structure, language,
38 and format” means style, arrangement, and overall content of a
39 benefit.

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

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

6 (1) Standardized Medicare supplement benefit plan A shall
7 include only the following: the basic (core) benefits as defined in
8 subdivision (b) of Section 1358.81.

9 (2) Standardized Medicare supplement benefit plan B shall
10 include only the following: the basic (core) benefit as defined in
11 subdivision (b) of Section 1358.81, plus 100 percent of the
12 Medicare Part A deductible as defined in paragraph (1) of
13 subdivision (c) of Section 1358.81.

14 (3) Standardized Medicare supplement benefit plan C shall
15 include only the following: the basic (core) benefit as defined in
16 subdivision (b) of Section 1358.81, plus 100 percent of the
17 Medicare Part A deductible, skilled nursing facility care, 100
18 percent of the Medicare Part B deductible, and medically necessary
19 emergency care in a foreign country, as defined in paragraphs (1),
20 (3), (4), and (6) of subdivision (c) of Section 1358.81, respectively.

21 (4) Standardized Medicare supplement benefit plan D shall
22 include only the following: the basic (core) benefit, as defined in
23 subdivision (b) of Section 1358.81, plus 100 percent of the
24 Medicare Part A deductible, skilled nursing facility care, and
25 medically necessary emergency care in an foreign country, as
26 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
27 1358.81, respectively.

28 (5) Standardized Medicare supplement plan F shall include only
29 the following: the basic (core) benefit as defined in subdivision
30 (b) of Section 1358.81, plus 100 percent of the Medicare Part A
31 deductible, skilled nursing facility care, 100 percent of the
32 Medicare Part B deductible, 100 percent of the Medicare Part B
33 excess charges, and medically necessary emergency care in a
34 foreign country, as defined in paragraphs (1), (3), (4), (5), and (6)
35 of subdivision (c) of Section 1358.81, respectively.

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

(A) The basic (core) benefit as defined in subdivision (b) of Section 1358.81, 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 1358.81, 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 1358.81, 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 1358.81, 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

1 shall accept the issuer's payment as payment in full and may not
2 bill the insured for any balance.

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

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

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

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

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

25 (I) Coverage of 100 percent of the cost sharing for Medicare
26 Part B preventive services after the enrollee or subscriber pays the
27 Part B deductible.

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

35 (9) Standardized Medicare supplement plan L shall include only
36 the following:

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

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

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

4 (10) Standardized Medicare supplement plan M shall include
5 only the following: the basic (core) benefit as defined in
6 subdivision (b) of Section 1358.81, plus 50 percent of the Medicare
7 Part A deductible, skilled nursing facility care, and medically
8 necessary emergency care in a foreign country, as defined in
9 paragraphs (2), (3), and (6) of subdivision (c) of Section 1358.81,
10 respectively.

11 (11) Standardized Medicare supplement plan N shall include
12 only the following: the basic (core) benefit as defined in
13 subdivision (b) of Section 1358.81, plus 100 percent of the
14 Medicare Part A deductible, skilled nursing facility care, and
15 medically necessary emergency care in a foreign country, as
16 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
17 1358.81, respectively, with copayments in the following amounts:

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

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

26 (f) An issuer may, with the prior approval of the director, offer
27 contracts with new or innovative benefits, in addition to the
28 standardized benefits provided in a contract that otherwise complies
29 with the applicable standards. The new or innovative benefits shall
30 include only benefits that are appropriate to Medicare supplement
31 contracts, are new or innovative, are not otherwise available, and
32 are cost effective. Approval of new or innovative benefits shall
33 not adversely impact the goal of Medicare supplement
34 simplification. New or innovative benefits shall not include an
35 outpatient prescription drug benefit. New or innovative benefits
36 shall not be used to change or reduce benefits, including a change
37 of any cost-sharing provision, in any standardized plan.

38 SEC. 8. Section 1358.11 of the Health and Safety Code is
39 amended to read:

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

13 (2) An issuer shall make available Medicare supplement benefit
14 plans A, B, C, and F, if currently available, to an applicant who
15 qualifies under this subdivision who is 64 years of age or younger
16 and who does not have end-stage renal disease. An issuer shall
17 also make available to those applicants, Medicare supplement
18 benefit plan H, I, or J, if currently available, and commencing
19 January 1, 2007, shall make available to them Medicare supplement
20 benefit plan K or L, if currently available. The selection among
21 Medicare supplement benefit plan H, I, or J and the selection
22 between Medicare supplement benefit plan K or L shall be made
23 at the issuer's discretion.

24 (3) This section and Section 1358.12 do not prohibit an issuer
25 in determining subscriber rates from treating applicants who are
26 under 65 years of age and are eligible for Medicare Part B as a
27 separate risk classification. ~~This section shall not be construed as~~
28 ~~preventing the exclusion of benefits for preexisting conditions as~~
29 ~~defined in paragraph (1) of subdivision (a) of Section 1358.8 or~~
30 ~~paragraph (1) of subdivision (a) of Section 1358.81.~~

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

37 (2) If the applicant qualifies under subdivision (a) and submits
38 an application during the time period referenced in subdivision (a)
39 and, as of the date of application, has had a continuous period of
40 creditable coverage that is less than six months, the issuer shall

1 reduce the period of any preexisting condition exclusion by the
2 aggregate of the period of creditable coverage applicable to the
3 applicant as of the enrollment date. The manner of the reduction
4 under this subdivision shall be as specified by the director.

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

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

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

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

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

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

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

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

7 (g) (1) An individual whose coverage was terminated by a
8 Medicare Advantage plan shall be entitled to an additional 60-day
9 open enrollment period to be added on to and run consecutively
10 after any open enrollment period authorized by federal law or
11 regulation, for any and all Medicare supplement coverage available
12 on a guaranteed basis under state and federal law or regulations
13 for persons terminated by their Medicare Advantage plan.

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

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

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

1 SEC. 9. Section 1358.12 of the Health and Safety Code is
2 amended to read:

3 1358.12. (a) (1) With respect to the guaranteed issue of a
4 Medicare supplement contract, eligible persons are those
5 individuals described in subdivision (b) who seek to enroll under
6 the contract during the period specified in subdivision (c), and who
7 submit evidence of the date of termination or disenrollment or
8 enrollment in Medicare Part D with the application for a Medicare
9 supplement contract.

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

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

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

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

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

22 (1) The individual is enrolled under an employee welfare benefit
23 plan that provides health benefits that supplement the benefits
24 under Medicare, ~~and the plan either terminates or ceases to provide~~
25 ~~all of those supplemental health benefits to the individual, and the~~
26 ~~employer no longer provides the individual with insurance that~~
27 ~~covers all of the payment for the 20-percent coinsurance.~~

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

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

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

35 (C) The individual is no longer eligible to elect the plan because
36 of a change in the individual's place of residence or other change
37 in circumstances specified by the secretary. Those changes in
38 circumstances shall not include termination of the individual's
39 enrollment on the basis described in Section 1851(g)(3)(B) of the
40 federal Social Security Act where the individual has not paid

1 premiums on a timely basis or has engaged in disruptive behavior
2 as specified in standards under Section 1856, or the plan is
3 terminated for all individuals within a residence area.

4 (D) The Medicare Advantage plan in which the individual is
5 enrolled reduces any of its benefits or increases the amount of cost
6 sharing or discontinues for other than good cause relating to quality
7 of care, its relationship or contract under the plan with a provider
8 who is currently furnishing services to the individual. An individual
9 shall be eligible under this subparagraph for a Medicare supplement
10 contract issued by the same issuer through which the individual
11 was enrolled at the time the reduction, increase, or discontinuance
12 described above occurs or, commencing January 1, 2007, for one
13 issued by a subsidiary of the parent company of that issuer or by
14 a network that contracts with the parent company of that issuer.

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

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

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

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

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

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

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

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

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

1 (iii) An organization under an agreement under Section
2 1833(a)(1)(A) of the Social Security Act (health care prepayment
3 plan).

4 (iv) An organization under a Medicare Select policy.

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

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

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

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

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

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

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

29 (B) The subsequent enrollment under subparagraph (A) is
30 terminated by the individual during any period within the first 12
31 months of the subsequent enrollment (during which the enrollee
32 is permitted to terminate the subsequent enrollment under Section
33 1851(e) of the federal Social Security Act).

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

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

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

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

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

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

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

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

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

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

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment

1 period for Medicare Part D and ends on the date that is 63 days
2 after the effective date of the individual's coverage under Medicare
3 Part D.

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

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

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

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

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

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

1 individual is entitled to a Medicare supplement contract that has
2 a benefit package classified as Plan A, B, C, F (including a high
3 deductible Plan F), K, or L offered by any issuer.

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

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

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

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

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

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

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

6 ~~SEC. 9.~~

7 *SEC. 10.* Section 1358.13 of the Health and Safety Code is
8 amended to read:

9 1358.13. (a) An issuer shall comply with Section 1882(c)(3)
10 of the federal Social Security Act (as enacted by Section
11 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
12 of 1987 (OBRA), Public Law 100-203) by doing all of the
13 following:

14 (1) Accepting a notice from a Medicare Administrative
15 Contractor, formerly known as a fiscal intermediary or carrier, on
16 dually assigned claims submitted by participating physicians and
17 suppliers as a claim for benefits in place of any other claim form
18 otherwise required and making a payment determination on the
19 basis of the information contained in that notice.

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

22 (3) Paying the participating physician or supplier directly.

23 (4) Furnishing, at the time of enrollment, each enrollee with a
24 card listing the contract name, number, and a central mailing
25 address to which notices respecting coverage from a Medicare
26 Administrative Contractor may be sent.

27 (5) Paying user fees established under Section 1395u(h)(3)(B)
28 of Title 42 of the United States Code, for claim notices that are
29 transmitted electronically or otherwise.

30 (6) Providing to the secretary, at least annually, a central mailing
31 address to which all claims may be sent by Medicare
32 Administrative Contractors.

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

36 ~~SEC. 10.~~

37 *SEC. 11.* Section 1358.17 of the Health and Safety Code is
38 amended to read:

39 1358.17. (a) (1) Medicare supplement contracts shall include
40 a renewal or continuation provision. The language or specifications

1 of the provision shall be consistent with subdivision (a) of Section
2 1365 and the rules adopted thereunder. The provision shall be
3 appropriately captioned and shall appear on the first page of the
4 contract, and shall include any reservation by the issuer of the right
5 to change prepaid or periodic charges and any automatic renewal
6 increases based on the enrollee's age.

7 (2) The contract shall contain the provisions required to be set
8 forth by Section 1300.67.4 of Title 28 of the California Code of
9 Regulations.

10 (b) (1) Except for contract amendments by which the issuer
11 effectuates a request made in writing by the enrollee, exercises a
12 specifically reserved right under a Medicare supplement contract,
13 or is required to reduce or eliminate benefits to avoid duplication
14 of Medicare benefits, all amendments to a Medicare supplement
15 contract after the date of issue or upon reinstatement or renewal
16 that reduce or eliminate benefits or coverage in the contract shall
17 require a signed acceptance by the subscriber. After the date of
18 contract issue, any amendment that increases benefits or coverage
19 with a concomitant increase in prepaid or periodic charges during
20 the contract term shall be agreed to in writing signed by the
21 subscriber, unless the benefits are required by the minimum
22 standards for Medicare supplement contracts, or if the increased
23 benefits or coverage is required by law. If a separate additional
24 charge is made for benefits provided in connection with contract
25 amendments, the charge shall be set forth in the contract.

26 (2) An issuer shall not in any way reduce or eliminate any
27 benefit or coverage under a Medicare supplement contract at any
28 time after the date of entering the contract, including dates of
29 reinstatement or renewal, unless and until the change is voluntarily
30 agreed to in writing signed by the subscriber or enrollee, or is
31 required to reduce or eliminate benefits to avoid duplication of
32 Medicare benefits. The issuer shall not increase benefits or
33 coverage with a concomitant increase in prepaid or periodic charges
34 during the term of the contract unless and until the change is
35 voluntarily agreed to in writing signed by the subscriber or enrollee
36 or unless the increased benefits or coverage is required by law or
37 regulation.

38 (c) Medicare supplement contracts shall not provide for the
39 payment of benefits based on standards described as "usual and

1 customary,” “reasonable and customary,” or words of similar
2 import.

3 (d) If a Medicare supplement contract contains any limitations
4 with respect to preexisting conditions, those limitations shall appear
5 as a separate paragraph of the contract and be labeled as
6 “Preexisting Condition Limitations.”

7 (e) (1) Medicare supplement contracts shall have a notice
8 prominently printed in no less than 10-point uppercase type, on
9 the cover page of the contract or attached thereto stating that the
10 applicant shall have the right to return the contract within 30 days
11 of its receipt via regular mail, and to have any charges refunded
12 in a timely manner if, after examination of the contract, the covered
13 person is not satisfied for any reason. The return shall void the
14 contract from the beginning, and the parties shall be in the same
15 position as if no contract had been issued.

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

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

24 (f) (1) Issuers of health care service plan contracts that provide
25 hospital or medical expense coverage on an expense incurred or
26 indemnity basis to persons eligible for Medicare shall provide to
27 those applicants a guide to health insurance for people with
28 Medicare in the form developed jointly by the National Association
29 of Insurance Commissioners and the Centers for Medicare and
30 Medicaid Services and in a type size no smaller than 12-point type.
31 Delivery of the guide shall be made whether or not the contracts
32 are advertised, solicited, or issued for delivery as Medicare
33 supplement contracts as defined in this article. Except in the case
34 of direct response issuers, delivery of the guide shall be made to
35 the applicant at the time of application, and acknowledgment of
36 receipt of the guide shall be obtained by the issuer. Direct response
37 issuers shall deliver the guide to the applicant upon request, but
38 not later than at the time the contract 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 enrollees and subscribers of modifications it has made to Medicare supplement contracts in a format acceptable to the director. 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 contract.

(2) Inform each enrollee as to when any adjustment in prepaid or periodic charges is to be made due to changes in Medicare.

(h) The notice of benefit modifications and any adjustments of prepaid or periodic charges 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 contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the contract shall accompany the contract 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, information about prepaid or periodic charges, 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 authorized by federal law shall be shown on the cover page, and

1 the plans that are offered by the issuer shall be prominently
2 identified. Information about prepaid or periodic charges for plans
3 that are offered shall be shown on the cover page or immediately
4 following the cover page and shall be prominently displayed. The
5 charge and mode shall be stated for all plans that are offered to
6 the prospective applicant. All possible charges for the prospective
7 applicant shall be illustrated.

8 (3) (A) The following shall only apply to contracts sold for
9 effective dates prior to June 1, 2010:

10 (i) The outline of coverage shall include the items, and in the
11 same order, specified in the chart set forth in Section 17 of the
12 Model Regulation to implement the NAIC Medicare Supplement
13 Insurance Minimum Standards Model Act, as adopted by the
14 National Association of Insurance Commissioners in 2004.

15 (ii) The cover page shall contain the 12-plan (A-L) charts. The
16 plans offered by the issuer shall be clearly identified. Innovative
17 benefits shall be explained in a manner approved by the director.

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

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

25 (ii) The cover page shall contain all Medicare supplement plan
26 charts A to D, inclusive, F, F with high deductible, G, and K to N,
27 inclusive. The plans offered by the issuer shall be clearly identified.
28 Innovative benefits shall be explained in a manner approved by
29 the director.

30 The text shall read: “Medicare supplement contracts can be sold
31 in only standard plans. This chart shows the benefits included in
32 each plan. Every insurance company must offer Plan A. Some
33 plans may not be available. Plans E, H, I, and J are no longer
34 available for sale. [This sentence shall not appear after June 1,
35 2011.]”

36 (4) The disclosure pages shall be in the language and format
37 described below in no less than 12-point type.

1 INFORMATION ABOUT PREPAID OR PERIODIC
2 CHARGES

3
4 [Insert plan's name] can only raise your charges if it raises the
5 charge for all contracts like yours in this state. [If the charge is
6 based on the increasing age of the enrollee, include information
7 specifying when charges will change.]

8
9 DISCLOSURES

10
11 Use this outline to compare benefits and charges among policies.
12 [The following additional language shall be included under
13 "DISCLOSURES" for contracts with effective dates on or after
14 June 1, 2010, but shall not appear after June 1, ~~2011~~ 2011.]

15 This outline shows benefits and premiums of policies sold for
16 effective dates on or after June 1, 2010. Policies sold for effective
17 dates prior to June 1, 2010, have different benefits and premiums.
18 Plans E, H, I, and J are no longer available for sale.

19
20 READ YOUR POLICY VERY CAREFULLY

21
22 This is only an outline describing the most important features
23 of your Medicare supplement plan contract. This is not the plan
24 contract and only the actual contract provisions will control. You
25 must read the contract itself to understand all of the rights and
26 duties of both you and [insert the health care service plan's name].

27
28 RIGHT TO RETURN POLICY

29
30 If you find that you are not satisfied with your contract, you may
31 return it to [insert plan's address]. If you send the contract back
32 to us within 30 days after you receive it, we will treat the contract
33 as if it had never been issued and return all of your payments.

34
35 POLICY REPLACEMENT

36
37 If you are replacing other health coverage, do NOT cancel it
38 until you have actually received your new contract and are sure
39 you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither [insert the health care service plan's name] nor 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 further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information. [If the contract is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded. [The charts displaying the features of each benefit plan offered by the issuer shall use the uniform format and language shown in the charts set forth in Section 17 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as most recently adopted by the National Association of Insurance Commissioners. No more than four benefit plans may be shown on one chart. For purposes of illustration, charts for each benefit plan are set forth below. An issuer may use additional benefit plan designations on these charts.]

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

(k) Notwithstanding Section 1300.63.2 of Title 28 of the California Code of Regulations, no issuer shall combine the evidence of coverage and disclosure form into a single document relating to a contract that supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage.

(l) The director 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

1 applicants pursuant to this section, including the format of tables,
2 charts, and other information.

3 (m) (1) Any health care service plan contract, other than a
4 Medicare supplement contract, a contract issued pursuant to a
5 contract under Section 1876 of the federal Social Security Act (42
6 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other
7 contract identified in subdivision (b) of Section 1358.3, issued for
8 delivery in this state to persons eligible for Medicare, shall notify
9 enrollees under the contract that the contract is not a Medicare
10 supplement contract. The notice shall either be printed or attached
11 to the first page of the outline of coverage delivered to enrollees
12 under the contract, or if no outline of coverage is delivered, to the
13 first page of the contract delivered to enrollees. The notice shall
14 be in no less than 12-point type and shall contain the following
15 language:

16
17 “THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT.
18 If you are eligible for Medicare, review the Guide to Health
19 Insurance for People with Medicare available from the company.”
20

21 (2) Applications provided to persons eligible for Medicare for
22 the health insurance contracts described in paragraph (1) shall
23 disclose the extent to which the contract duplicates Medicare in a
24 manner required by the director. The disclosure statement shall be
25 provided as a part of, or together with, the application for the
26 contract.

27 (n) A Medicare supplement contract that does not cover
28 custodial care shall, on the cover page of the outline of coverages,
29 contain the following statement in uppercase type: “THIS POLICY
30 DOES NOT COVER CUSTODIAL CARE IN A SKILLED
31 NURSING CARE FACILITY.”

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

35 ~~SEC. 11.~~

36 *SEC. 12.* Section 1358.18 of the Health and Safety Code is
37 amended to read:

38 1358.18. In the interest of full and fair disclosure, and to assure
39 the availability of necessary consumer information to potential
40 subscribers or enrollees not possessing a special knowledge of

1 Medicare, health care service plans, or Medicare supplement
2 contracts, an issuer shall comply with the following provisions:

3 (a) Application forms shall include the following questions
4 designed to elicit information as to whether, as of the date of the
5 application, the applicant currently has Medicare supplement,
6 Medicare Advantage, Medi-Cal coverage, or another health
7 insurance policy or certificate or plan contract in force or whether
8 a Medicare supplement contract is intended to replace any other
9 disability policy or certificate, or plan contract, presently in force.
10 A supplementary application or other form to be signed by the
11 applicant and solicitor containing those questions and statements
12 may be used.

13
14 “(Statements)
15

16 (1) You do not need more than one Medicare supplement policy
17 or contract.

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

20 (3) You may be eligible for benefits under Medi-Cal or Medicaid
21 and may not need a Medicare supplement contract.

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

37 (5) If you are eligible for, and have enrolled in, a Medicare
38 supplement contract by reason of disability and you later become
39 covered by an employer or union-based group health plan, the
40 benefits and premiums under your Medicare supplement contract

1 can be suspended, if requested, while you are covered under the
2 employer or union-based group health plan. If you suspend your
3 Medicare supplement contract under these circumstances and later
4 lose your employer or union-based group health plan, your
5 suspended Medicare supplement contract or if that is no longer
6 available, a substantially equivalent contract, will be reinstituted
7 if requested within 90 days of losing your employer or union-based
8 group health plan. If the Medicare supplement contract provided
9 coverage for outpatient prescription drugs and you enrolled in
10 Medicare Part D while your contract was suspended, the
11 reinstituted contract will not have outpatient prescription drug
12 coverage, but will otherwise be substantially equivalent to your
13 coverage before the date of the suspension.

14 (6) Counseling services are available in this state to provide
15 advice concerning your purchase of Medicare supplement coverage
16 and concerning medical assistance through the Medi-Cal or
17 Medicaid Program, including benefits as a qualified Medicare
18 beneficiary (QMB) and a specified low-income Medicare
19 beneficiary (SLMB). Information regarding counseling services
20 may be obtained from the California Department of Aging.

21
22 (Questions)
23

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

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

32 To the best of your knowledge,

33 (1) (a) Did you turn 65 years of age in the last 6 months

34 Yes_____ No_____

35 (b) Did you enroll in Medicare Part B in the last 6 months

36 Yes_____ No_____

37 (c) If yes, what is the effective date _____

38 (2) Are you covered for medical assistance through California's
39 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 contract

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 contract

Yes_____ No_____

(c) Was this your first time in this type of Medicare plan

Yes_____ No_____

(d) Did you drop a Medicare supplement contract to enroll in the Medicare plan

Yes_____ No_____

(4) (a) Do you have another Medicare supplement policy or certificate or contract 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 or certificate or contract with this contract

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

1 _____
2 _____
3 _____
4 (b) What are your dates of coverage under the other policy
5 START __/__/__ END __/__/__
6 (If you are still covered under the other policy, leave “END”
7 blank).

8 (b) Solicitors shall list any other health insurance policies or
9 plan contracts they have sold to the applicant as follows:

10 (1) List policies and contracts sold that are still in force.
11 (2) List policies and contracts sold in the past five years that
12 are no longer in force.

13 (c) An issuer issuing Medicare supplement contracts without a
14 solicitor or solicitor firm (a direct response issuer) shall return to
15 the applicant, upon delivery of the contract, a copy of the
16 application or supplemental forms, signed by the applicant and
17 acknowledged by the issuer.

18 (d) Upon determining that a sale will involve replacement of
19 Medicare supplement coverage, any issuer, other than a direct
20 response issuer, or its agent, shall furnish the applicant, prior to
21 issuance for delivery of the Medicare supplement contract, a notice
22 regarding replacement of Medicare supplement coverage. One
23 copy of the notice signed by the applicant and the agent, except
24 where the coverage is sold without an agent, shall be provided to
25 the applicant and an additional signed copy shall be retained by
26 the issuer. A direct response issuer shall deliver to the applicant
27 at the time of the issuance of the contract the notice regarding
28 replacement of Medicare supplement coverage.

29 (e) The notice required by subdivision (d) for an issuer shall be
30 provided in substantially the following form in no less than
31 12-point type:

32
33 NOTICE TO APPLICANT REGARDING REPLACEMENT
34 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
35 ADVANTAGE
36
37

38 (Company name and address)
39
40

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

3 According to [your application] [information you have
4 furnished], you intend to lapse or otherwise terminate an existing
5 Medicare supplement policy or contract or Medicare Advantage
6 plan and replace it with a contract to be issued by [Plan Name].
7 Your contract to be issued by [Plan Name] will provide 30 days
8 within which you may decide without cost whether you desire to
9 keep the contract. You should review this new coverage carefully.
10 Compare it with all accident and sickness coverage you now have.
11 Terminate your present policy or contract only if, after due
12 consideration, you find that purchase of this Medicare supplement
13 coverage is a wise decision. STATEMENT TO APPLICANT BY
14 PLAN, SOLICITOR, SOLICITOR FIRM, OR OTHER
15 REPRESENTATIVE:

16 (1) I have reviewed your current medical or health coverage.
17 To the best of my knowledge, the replacement of coverage involved
18 in this transaction does not duplicate coverage or, if applicable,
19 Medicare Advantage coverage because you intend to terminate
20 your existing Medicare supplement coverage or leave your
21 Medicare Advantage plan. The replacement contract is being
22 purchased for the following reason (check one):__ Additional
23 benefits. __No change in benefits, but lower premiums or charges.
24 __Fewer benefits and lower premiums or charges.__ Plan has
25 outpatient prescription drug coverage and applicant is enrolled in
26 Medicare Part D.__ Disenrollment from a Medicare Advantage
27 plan. Reasons for disenrollment:__ Other. (please specify)
28 _____

29 (2) If the issuer of the Medicare supplement contract being
30 applied for does not *impose*, or is otherwise prohibited from
31 imposing, preexisting condition limitations, please skip to statement
32 3 below. Health conditions that you may presently have
33 (preexisting conditions) may not be immediately or fully covered
34 under the new contract. This could result in denial or delay of a
35 claim for benefits under the new contract, whereas a similar claim
36 might have been payable under your present contract.

37 (3) State law provides that your replacement Medicare
38 supplement contract may not contain new preexisting conditions,
39 waiting periods, elimination periods, or probationary periods. The
40 plan will waive any time periods applicable to preexisting

1 conditions, waiting periods, elimination periods, or probationary
2 periods in the new coverage for similar benefits to the extent that
3 time was spent (depleted) under the original contract.

4 (4) If you still wish to terminate your present policy or contract
5 and replace it with new coverage, be certain to truthfully and
6 completely answer any and all questions on the application
7 concerning your medical and health history. Failure to include all
8 material medical information on an application requesting that
9 information may provide a basis for the plan to deny any future
10 claims and to refund your prepaid or periodic payment as though
11 your contract had never been in force. After the application has
12 been completed and before you sign it, review it carefully to be
13 certain that all information has been properly recorded.

14 (5) Do not cancel your present Medicare supplement coverage
15 until you have received your new contract and are sure you want
16 to keep it.

17
18 _____
19 (Signature of Solicitor, Solicitor Firm, or Other Representative)

20 [Typed Name and Address of Plan, Solicitor, or Solicitor Firm]
21 _____

22 (Applicant's Signature)

23 _____
24 (Date)
25

26 (f) The application form or other consumer information for
27 persons eligible for Medicare and used by an issuer shall contain
28 as an attachment a Medicare supplement buyer's guide in the form
29 approved by the director. The application or other consumer
30 information, containing as an attachment the buyer's guide, shall
31 be mailed or delivered to each applicant applying for that coverage
32 at or before the time of application and, to establish compliance
33 with this subdivision, the issuer shall obtain an acknowledgment
34 of receipt of the attached buyer's guide from each applicant. No
35 issuer shall make use of or otherwise disseminate any buyer's
36 guide that does not accurately outline current Medicare supplement
37 benefits. No issuer shall be required to provide more than one copy
38 of the buyer's guide to any applicant.

39 (g) An issuer may comply with the requirement of this section
40 in the case of group contracts by causing the subscriber (1) to

1 disseminate copies of the disclosure form containing as an
2 attachment the buyer's guide to all persons eligible under the group
3 contract at the time those persons are offered the Medicare
4 supplement plan, and (2) collecting and forwarding to the issuer
5 an acknowledgment of receipt of the disclosure form containing
6 as an attachment the buyer's guide from each enrollee.

7 ~~(h) Commencing January 1, 2007, an issuer shall not require or~~
8 ~~request health information from an applicant who is guaranteed~~
9 ~~issuance of any Medicare supplement coverage or require or request~~
10 ~~the applicant to sign a form required by the federal Health~~
11 ~~Insurance Portability and Accountability Act of 1996. The~~
12 ~~application form shall include a clear and conspicuous statement~~
13 ~~that the applicant is not required to provide health information or~~
14 ~~to sign a form required by the federal Health Insurance Portability~~
15 ~~and Accountability Act of 1996 during a period of guaranteed~~
16 ~~issuance of any Medicare supplement coverage and shall inform~~
17 ~~the applicant of periods of guaranteed issuance of Medicare~~
18 ~~supplement coverage. A supplementary application or other form~~
19 ~~containing those statements that the applicant and solicitor are~~
20 ~~required to sign may be used for this purpose. This subdivision~~
21 ~~shall not prohibit an issuer from requiring proof of eligibility for~~
22 ~~a guaranteed issuance of Medicare supplement coverage.~~

23 *(h) For an individual who is subject to an open enrollment*
24 *period or who is guaranteed issuance of any Medicare supplement*
25 *coverage as described in Section 1358.11 or 1358.12, an issuer*
26 *shall not require or use, for the purpose of determining eligibility*
27 *or premium levels, or for any other purpose not explicitly disclosed*
28 *to the applicant pursuant to this subdivision, the applicant's health*
29 *information, including health information acquired in compliance*
30 *with the federal Health Insurance Portability and Accountability*
31 *Act of 1996, or require an applicant to sign a form required by*
32 *the federal Health Insurance Portability and Accountability Act*
33 *of 1996. A statement of this prohibition shall be included on the*
34 *application in clear and conspicuous language, in addition to the*
35 *open enrollment and guaranteed issue periods described in*
36 *Sections 1358.11 and 1358.12. This subdivision shall not prohibit*
37 *an issuer from requiring proof of eligibility for a guaranteed*
38 *issuance of Medicare supplement coverage. This subdivision shall*
39 *not preclude an issuer from requesting an applicant to voluntarily*
40 *provide health information, provided that the issuer obtains*

1 *authorization in compliance with the applicable requirements*
2 *under the federal Health Insurance Portability and Accountability*
3 *Act of 1996.*

4 ~~SEC. 12.~~

5 *SEC. 13.* Section 1358.20 of the Health and Safety Code is
6 amended to read:

7 1358.20. (a) An issuer, directly or through solicitors or other
8 representatives, shall do each of the following:

9 (1) Establish marketing procedures to ensure that any
10 comparison of Medicare supplement coverage by its solicitors or
11 other representatives will be fair and accurate.

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

14 (3) Display prominently by type, stamp, or other appropriate
15 means, on the first page of the outline of coverage and contract,
16 the following:

17
18 “Notice to buyer: This Medicare supplement contract may not
19 cover all of your medical expenses.”

20
21 (4) Inquire and otherwise make every reasonable effort to
22 identify whether a prospective applicant for a Medicare supplement
23 contract already has health care coverage and the types and
24 amounts of that coverage.

25 (5) Provide, on the application form for Medicare supplement
26 contracts, a statement that reads as follows: “A rate guide is
27 available that compares the policies sold by different insurers. You
28 can obtain a copy of this rate guide by calling the Department of
29 Insurance’s consumer toll-free telephone number
30 (1-800-927-HELP), by calling the Health Insurance Counseling
31 and Advocacy Program (HICAP) toll-free telephone number
32 (1-800-434-0222), or by accessing the Department of Insurance’s
33 Internet Web site (www.insurance.ca.gov).”

34 (6) Establish auditable procedures for verifying compliance
35 with this subdivision.

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

38 (1) Twisting, which means knowingly making any misleading
39 representation or incomplete or fraudulent comparison of any
40 coverages or issuers for the purpose of inducing or tending to

1 induce, any person to lapse, forfeit, surrender, terminate, retain,
2 pledge, assign, borrow on, or convert any coverage or to take out
3 coverage with another plan or insurer.

4 (2) High pressure tactics, which means employing any method
5 of marketing having the effect of or tending to induce the purchase
6 of coverage through force, fright, threat, whether explicit or
7 implied, or undue pressure to purchase or recommend the purchase
8 of coverage.

9 (3) Cold lead advertising, which means making use directly or
10 indirectly of any method of marketing that fails to disclose in a
11 conspicuous manner that a purpose of the method of marketing is
12 the solicitation of coverage and that contact will be made by a
13 health care service plan or its representative.

14 (c) The terms “Medicare supplement,” “Medigap,” “Medicare
15 Wrap-Around” and words of similar import shall not be used unless
16 the contract is issued in compliance with this article.

17 ~~SEC. 13.~~

18 *SEC. 14.* Section 1358.24 is added to the Health and Safety
19 Code, to read:

20 1358.24. This section applies to all contracts that become
21 effective on or after May 21, 2009.

22 (a) In addition to the requirements set forth under Sections
23 1365.5 and 1374.7, an issuer of a Medicare supplement contract
24 shall adhere to the requirements imposed by the federal Genetic
25 Information Nondiscrimination Act of 2008 (Public Law 110-233),
26 as follows:

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

32 (2) The issuer shall not discriminate in the pricing of the
33 contract, including the adjustment of prepaid or periodic charges,
34 of an individual on the basis of the genetic information with respect
35 to that individual or a family member of the individual.

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

39 (1) Deny or condition the issuance or effectiveness of the
40 contract or increase the prepaid or periodic charge for a group

1 based on the manifestation of a disease or disorder of an enrollee,
2 subscriber, or applicant.

3 (2) Increase the prepaid or periodic charge for any contract
4 issued to an individual based on the manifestation of a disease or
5 disorder of an individual who is covered under the contract. For
6 purposes of this paragraph, the manifestation of a disease or
7 disorder in one individual shall not also be used as genetic
8 information about other group members and to further increase
9 the prepaid or periodic charge for the group.

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

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

20 (e) For purposes of carrying out subdivision (d), an issuer of a
21 Medicare supplement contract may request only the minimum
22 amount of information necessary to accomplish the intended
23 purpose.

24 (f) Notwithstanding subdivision (b) of Section 1374.7 or
25 subdivision (c), an issuer of a Medicare supplement contract may
26 request, but not require, that an individual or a family member of
27 that individual undergo a genetic test if each of the following
28 conditions is met:

29 (1) The request is made pursuant to research that complies with
30 Part 46 of Title 45 of the Code of Federal Regulations, or
31 equivalent federal regulations, and any applicable state or local
32 law or regulations for the protection of human subjects in research.

33 (2) The issuer clearly indicates both of the following to each
34 individual, or in the case of a minor child, to the legal guardian of
35 that child, to whom the request is made:

36 (A) Compliance with the request is voluntary.

37 (B) Noncompliance will have no effect on enrollment status,
38 prepaid or periodic charges, or contribution amounts.

39 (3) No genetic information collected or acquired under this
40 subdivision shall be used for any prohibited purpose described in

1 Section 1365.5 or subdivision (a) of Section 1374.7, as well as any
2 of the following: underwriting, determination of eligibility to enroll
3 or maintain enrollment status, determination of prepaid or periodic
4 charges, or the issuance, renewal, or replacement of a contract.

5 (4) The issuer notifies the United States Secretary of Health and
6 Human Services and the director in writing that the issuer is
7 conducting activities pursuant to the exception provided for under
8 this subdivision, including a description of the activities conducted.

9 (5) The issuer complies with any other conditions as the United
10 States Secretary of Health and Human Services may by regulation
11 require for activities conducted under this subdivision.

12 (g) An issuer of a Medicare supplement contract shall not
13 request, require, seek, or purchase genetic information for
14 underwriting purposes.

15 (h) An issuer of a Medicare supplement contract shall not
16 request, require, seek, or purchase genetic information with respect
17 to any individual or a family member of that individual prior to
18 the individual's enrollment under the contract in connection with
19 that enrollment.

20 (i) If an issuer of a Medicare supplement contract obtains genetic
21 information incidental to the requesting, requiring, or purchasing
22 of other information concerning any individual or a family member
23 of that individual, the request, requirement, or purchase shall not
24 be considered a violation of subdivision (h) if the request,
25 requirement, or purchase is not in violation of subdivision (g).
26 However, the issuer shall not use any genetic information obtained
27 under this section for any prohibited purpose described in this
28 section or in Sections 1365.5 and 1374.7.

29 (j) For the purposes of this section, the following definitions
30 shall apply:

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

34 (2) "Family member" means, with respect to an individual, any
35 other individual who is a first-degree, second-degree, third-degree,
36 or fourth-degree relative of the individual.

37 (3) "Genetic information" means, with respect to any individual,
38 information about the individual's genetic tests, the genetic tests
39 of family members of the individual, and the manifestation of a
40 disease or disorder in family members of the individual. The term

1 includes, with respect to any individual, any request for, or receipt
2 of, genetic services, or participation in clinical research which
3 includes genetic services, by the individual or any family member
4 of the individual. Any reference to genetic information concerning
5 an individual or family member of an individual who is a pregnant
6 woman, includes genetic information of any fetus carried by that
7 pregnant woman, or with respect to an individual or family member
8 utilizing reproductive technology, includes genetic information of
9 any embryo legally held by an individual or family member. The
10 term “genetic information” does not include information about the
11 sex or age of any individual.

12 (4) “Genetic services” means a genetic test, genetic education,
13 genetic counseling, including obtaining, interpreting, or assessing
14 genetic information.

15 (5) “Genetic test” means an analysis of human DNA, RNA,
16 chromosomes, proteins, or metabolites, that detect genotypes,
17 mutations, or chromosomal changes. The term “genetic test” does
18 not mean an analysis of proteins or metabolites that does not detect
19 genotypes, mutations, or chromosomal changes; or an analysis of
20 proteins or metabolites that is directly related to a manifested
21 disease, disorder, or pathological condition that could reasonably
22 be detected by a health care professional with appropriate training
23 and expertise in the field of medicine involved.

24 (6) “Underwriting purposes” includes all of the following:

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

27 (B) The computation of prepaid or periodic charges or
28 contribution amounts under the contract.

29 (C) The application of any preexisting condition exclusion under
30 the contract.

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

33 ~~SEC. 14.~~

34 *SEC. 15.* Section 785 of the Insurance Code is amended to
35 read:

36 785. (a) All insurers, brokers, agents, and others engaged in
37 the transaction of insurance owe a prospective insured who is 65
38 years of age or older, a duty of honesty, good faith, and fair dealing.
39 This duty is in addition to any other duty, whether express or
40 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 (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. 15.~~

SEC. 16. 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.

1 (c) “Certificate” means a certificate issued for delivery in this
2 state under a group Medicare supplement policy.

3 (d) “Certificate form” means the form on which the certificate
4 is issued for delivery by the issuer.

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

9 (f) (1) “Creditable coverage” means, with respect to an
10 individual, coverage of the individual provided under any of the
11 following:

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

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

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

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

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

28 (F) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

11 (D) Workers' compensation or similar insurance.

12 (E) Automobile medical payment insurance.

13 (F) Credit-only insurance.

14 (G) Coverage for onsite medical clinics.

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

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

22 (A) Limited scope dental or vision benefits.

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

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

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

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

30 (B) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

39 (g) "Employee welfare benefit plan" means a plan, fund, or
40 program of employee benefits as defined in Section 1002 of Title

1 29 of the United States Code (Employee Retirement Income
2 Security Act).

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

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

12 (j) “Medi-Cal” means California’s version of Medicaid under
13 Title XIX of the federal Social Security Act.

14 (k) “Medicare” means the Health Insurance for the Aged Act,
15 Title XVIII of the Social Security Amendments of 1965, as
16 amended.

17 (l) “Medicare Advantage plan” means a plan of coverage for
18 health benefits under Medicare Part C and includes:

19 (1) Coordinated care plans that provide health care services,
20 including, but not limited to, health care service plans (with or
21 without a point-of-service option), plans offered by
22 provider-sponsored organizations, and preferred provider
23 organizations plans.

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

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

27 (m) “Medicare supplement policy” means a group or individual
28 policy of health insurance, other than a policy issued pursuant to
29 a contract under Section 1876 of the federal Social Security Act
30 (42 U.S.C. Section 1395mm) or an issued policy under a
31 demonstration project specified in Section 1395ss(g)(1) of Title
32 42 of the United States Code, that is advertised, marketed, or
33 designed primarily as a supplement to reimbursements under
34 Medicare for the hospital, medical, or surgical expenses of persons
35 eligible for Medicare. “Medicare supplement policy” does not
36 include a Medicare Advantage plan established under Medicare
37 Part C, an outpatient prescription drug plan established under
38 Medicare Part D, or a health care prepayment plan that provides
39 benefits pursuant to an agreement under subparagraph (A) of

1 paragraph (1) of subsection (a) of Section 1833 of the Social
2 Security Act.

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

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

9 (p) "1990 standardized Medicare supplement benefit plan,"
10 "1990 standardized benefit plan," or "1990 plan" means a group
11 or individual policy of Medicare supplement insurance issued on
12 or after July 21, 1992, and with an effective date prior to June 1,
13 2010, and includes Medicare supplement insurance policies and
14 certificates renewed on or after that date which are not replaced
15 by the issuer at the request of the insured.

16 (q) "2010 standardized Medicare supplement benefit plan,"
17 "2010 standardized benefit plan," or "2010 plan" means a group
18 or individual policy of Medicare supplement insurance issued with
19 an effective date on or after June 1, 2010.

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

22 ~~SEC. 16.~~

23 *SEC. 17.* Section 10192.6 of the Insurance Code is amended
24 to read:

25 10192.6. (a) Except for permitted preexisting condition clauses
26 as described in Sections 10192.7, 10192.8, and 10192.81, a policy
27 or certificate shall not be advertised, solicited, or issued for delivery
28 as a Medicare supplement policy if the policy or certificate contains
29 limitations or exclusions on coverage that are more restrictive than
30 those of Medicare.

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

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

37 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of
38 Section 10192.8, a Medicare supplement policy with benefits for
39 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. 17.~~

SEC. 18. 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 with an effective date 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

1 Medicare will be changed automatically to coincide with any
2 changes in the applicable Medicare deductible, copayment, or
3 coinsurance amounts. Premiums may be modified to correspond
4 with those changes.

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

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

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

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

18 (C) If the Medicare supplement policy is terminated by the
19 master policyholder and is not replaced as provided under
20 subparagraph (E), the issuer shall offer certificate holders an
21 individual Medicare supplement policy that, at the option of the
22 certificate holder, either provides for continuation of the benefits
23 contained in the group policy or provides for benefits that otherwise
24 meet the requirements of one of the standardized policies defined
25 in this article.

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

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

39 (ii) If a Medicare supplement policy or certificate replaces
40 another Medicare supplement policy or certificate that has been

1 in force for six months or more, the replacing issuer shall not
2 impose an exclusion or limitation based on a preexisting condition.
3 If the original coverage has been in force for less than six months,
4 the replacing issuer shall waive any time period applicable to
5 preexisting conditions, waiting periods, elimination periods, or
6 probationary periods in the new policy or certificate to the extent
7 the time was spent under the original coverage.

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

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

22 (7) (A) (i) A Medicare supplement policy or certificate shall
23 provide that benefits and premiums under the policy or certificate
24 shall be suspended at the request of the policyholder or certificate
25 holder for the period, not to exceed 24 months, in which the
26 policyholder or certificate holder has applied for and is determined
27 to be entitled to Medi-Cal, but only if the policyholder or certificate
28 holder notifies the issuer of the policy or certificate within 90 days
29 after the date the individual becomes entitled to assistance. Upon
30 receipt of timely notice, the insurer shall return directly to the
31 insured that portion of the premium attributable to the period of
32 Medi-Cal eligibility, subject to adjustment for paid claims. If
33 suspension occurs and if the policyholder or certificate holder loses
34 entitlement to Medi-Cal, the policy or certificate shall be
35 automatically reinstituted, effective as of the date of termination
36 of entitlement, as of the termination of entitlement if the
37 policyholder or certificate holder provides notice of loss of
38 entitlement within 90 days after the date of loss and pays the
39 premium attributable to the period, effective as of the date of

1 termination of entitlement, or equivalent coverage shall be provided
2 if the prior form is no longer available.

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

15 (B) Reinstitution of coverages:

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

18 (ii) Shall provide for resumption of coverage that is substantially
19 equivalent to coverage in effect before the date of suspension. If
20 the suspended Medicare supplement policy provided coverage for
21 outpatient prescription drugs, reinstitution of the policy for a
22 Medicare Part D enrollee shall not include coverage for outpatient
23 prescription drugs but shall otherwise provide coverage that is
24 substantially equivalent to the coverage in effect before the date
25 of suspension.

26 (iii) Shall provide for classification of premiums on terms at
27 least as favorable to the policyholder or certificate holder as the
28 premium classification terms that would have applied to the
29 policyholder or certificate holder had the coverage not been
30 suspended.

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

37 (A) An issuer need not provide justification to the commissioner
38 if the insured replaces a 1990 standardized policy or certificate
39 with an issue age rated 2010 standardized policy or certificate at
40 the insured's original issue age and duration. If an insured's policy

1 or certificate to be replaced is priced on an issue age rate schedule
2 at the time of that offer, the rate charged to the insured for the new
3 exchanged policy shall recognize the policy reserve buildup, due
4 to the prefunding inherent in the use of an issue age rate basis, for
5 the benefit of the insured. The method proposed to be used by an
6 issuer shall be filed with the commissioner.

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

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

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

22 (9) A Medicare supplement policy may *not* limit coverage
23 exclusively to a single disease or affliction.

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

36 (1) Coverage of Part A Medicare eligible expenses for
37 hospitalization to the extent not covered by Medicare from the
38 61st day to the 90th day, inclusive, in any Medicare benefit period.

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

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

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

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

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

22 (7) Coverage of the actual cost, up to the legally billed amount,
23 of an annual cervical cancer screening test as provided in Section
24 10123.18, to the extent not paid by Medicare.

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

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

31 (2) With respect to skilled nursing facility care, coverage for
32 the actual billed charges up to the coinsurance amount from the
33 21st day to the 100th day, inclusive, in a Medicare benefit period
34 for posthospital skilled nursing facility care eligible under Medicare
35 Part A.

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

39 (4) With respect to 80 percent of the Medicare Part B excess
40 charges, coverage for 80 percent of the difference between the

1 actual Medicare Part B charge as billed, not to exceed any charge
2 limitation established by the Medicare Program or state law, and
3 the Medicare-approved Part B charge. If the insurer limits payment
4 to a limiting charge, the insurer has the burden to establish that
5 amount as the legal limit.

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

13 (6) With respect to the basic outpatient prescription drug benefit,
14 coverage for 50 percent of outpatient prescription drug charges,
15 after a two hundred fifty dollar (\$250) calendar year deductible,
16 to a maximum of one thousand two hundred fifty dollars (\$1,250)
17 in benefits received by the insured per calendar year, to the extent
18 not covered by Medicare. On and after January 1, 2006, no
19 Medicare supplement policy may be sold or issued if it includes
20 a prescription drug benefit.

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

29 (8) With respect to medically necessary emergency care in a
30 foreign country, coverage to the extent not covered by Medicare
31 for 80 percent of the billed charges for Medicare-eligible expenses
32 for medically necessary emergency hospital, physician, and medical
33 care received in a foreign country, which care would have been
34 covered by Medicare if provided in the United States and which
35 care began during the first 60 consecutive days of each trip outside
36 the United States, subject to a calendar year deductible of two
37 hundred fifty dollars (\$250), and a lifetime maximum benefit of
38 fifty thousand dollars (\$50,000). For purposes of this benefit,
39 “emergency care” shall mean care needed immediately because
40 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.

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

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

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

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

14 (iii) Coverage is limited to the following:

15 (I) No more than the number and type of at-home recovery visits
16 certified as necessary by the insured’s attending physician. The
17 total number of at-home recovery visits shall not exceed the number
18 of Medicare-approved home health care visits under a
19 Medicare-approved home care plan of treatment.

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

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

24 (IV) Seven visits in any one week.

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

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

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

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

34 (C) Coverage is excluded for the following:

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

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

39 (d) The standardized Medicare supplement benefit plan “K”
40 shall consist of the following benefits:

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

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

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

16 (4) With respect to the Medicare Part A deductible, coverage
17 for 50 percent of the Medicare Part A inpatient hospital deductible
18 amount per benefit period until the out-of-pocket limitation
19 described in paragraph (10) is met.

20 (5) With respect to skilled nursing facility care, coverage for
21 50 percent of the coinsurance amount for each day used from the
22 21st day to the 100th day, inclusive, in a Medicare benefit period
23 for posthospital skilled nursing facility care eligible under Medicare
24 Part A until the out-of-pocket limitation described in paragraph
25 (10) is met.

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

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

36 (8) Except for coverage provided in paragraph (9), coverage for
37 50 percent of the cost sharing otherwise applicable under Medicare
38 Part B after the policyholder pays the Part B deductible, until the
39 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

1 individual has reached the out-of-pocket limitation on annual
2 expenditures under Medicare Parts A and B of two thousand dollars
3 (\$2,000) in 2006, indexed each year by the appropriate inflation
4 adjustment specified by the secretary.

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

16 ~~SEC. 18.~~

17 *SEC. 19.* Section 10192.81 is added to the Insurance Code, to
18 read:

19 10192.81. The following standards are applicable to all
20 Medicare supplement policies or certificates delivered or issued
21 for delivery in this state with an effective date on or after June 1,
22 2010. No policy or certificate may be advertised, solicited,
23 delivered, or issued for delivery in this state as a Medicare
24 supplement policy or certificate unless it complies with these
25 benefit standards. No issuer may offer any 1990 standardized
26 Medicare supplement benefit plan for sale with an effective date
27 on or after June 1, 2010. Benefit standards applicable to Medicare
28 supplement policies and certificates issued with an effective date
29 prior to June 1, 2010, remain subject to the requirements of Section
30 10192.8.

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

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

1 from a physician within six months before the effective date of
2 coverage.

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

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

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

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

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

20 (B) The issuer shall not cancel or nonrenew the policy for any
21 reason other than nonpayment of premium or material
22 misrepresentation which is shown by the issuer to be material to
23 the acceptance for coverage. The contestability period for Medicare
24 supplement insurance shall be two years, pursuant to Section
25 10305.2.

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

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

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

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

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

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

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

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

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

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

39 (ii) If suspension occurs and if the policyholder or certificate
40 holder loses entitlement to medical assistance under Medi-Cal, the

1 policy or certificate shall be automatically reinstituted, effective
2 as of the date of termination of entitlement, as of the termination
3 of entitlement if the policyholder or certificate holder provides
4 notice of loss of entitlement within 90 days after the date of loss
5 and pays the premium attributable to the period, effective as of the
6 date of termination of entitlement or equivalent coverage shall be
7 provided if the prior form is no longer available.

8 (iii) Each Medicare supplement policy shall provide that benefits
9 and premiums under the policy shall be suspended (for any period
10 that may be provided by federal regulation) at the request of the
11 policyholder if the policyholder is entitled to benefits under Section
12 226(b) of the Social Security Act and is covered under a group
13 health plan (as defined in Section 1862(b)(1)(A)(v) of the Social
14 Security Act). If suspension occurs and if the policyholder or
15 certificate holder loses coverage under the group health plan, the
16 policy shall be automatically reinstituted (effective as of the date
17 of loss of coverage) if the policyholder provides notice of loss of
18 coverage within 90 days after the date of the loss and pays the
19 applicable premium.

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

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

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

26 (iii) Provide for classification of premiums on terms at least as
27 favorable to the policyholder or certificate holder as the premium
28 classification terms that would have applied to the policyholder
29 or certificate holder had the coverage not been suspended.

30 (b) With respect to the standards for basic (core) benefits for
31 benefit plans A, B, C, D, F, F with high deductible, G, M, and N,
32 every issuer of Medicare supplement insurance benefit plans shall
33 make available a policy or certificate including only the following
34 basic “core” package of benefits to each prospective insured. An
35 issuer may make available to prospective insureds any of the other
36 Medicare Supplement Insurance Benefit Plans in addition to the
37 basic (core) package, but not in lieu of it. However, the benefits
38 described in paragraphs (6) and (7) shall not be offered so long as
39 California is required to disallow these benefits for Medicare
40 beneficiaries by the centers for Medicare and Medicaid Services

1 or other agent of the federal government under Section 1395ss of
2 Title 42 of the United States Code.

3 (1) Coverage of Part A Medicare eligible expenses for
4 hospitalization to the extent not covered by Medicare from the
5 61st day through the 90th day, inclusive, in any Medicare benefit
6 period.

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

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

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

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

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

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

32 (8) Coverage of the actual cost, up to the legally billed amount,
33 of an annual cervical cancer screening test as provided in Section
34 10123.18, to the extent not paid by Medicare.

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

38 (1) With respect to the Medicare Part A deductible, coverage
39 for 100 percent of the Medicare Part A inpatient hospital deductible
40 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 posthospital 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 100 percent of the 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. 19.~~

SEC. 20. Section 10192.9 of the Insurance Code is amended to read:

10192.9. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992, and with an effective date 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

1 offered for sale in this state, except as may be permitted by
2 subdivision (f) and by Section 10192.10.

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

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

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

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

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

24 (3) Standardized Medicare supplement benefit plan C shall
25 include only the following: the core benefit, plus the Medicare
26 Part A deductible, skilled nursing facility care, Medicare Part B
27 deductible, and medically necessary emergency care in a foreign
28 country as defined in paragraphs (1), (2), (3), and (8) of subdivision
29 (c) of Section 10192.8, respectively.

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

36 (5) Standardized Medicare supplement benefit plan E shall
37 include only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, medically necessary
39 emergency care in a foreign country, and preventive medical care

1 as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of
2 Section 10192.8, respectively.

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

10 (7) Standardized Medicare supplement benefit high deductible
11 plan F shall include only the following: 100 percent of covered
12 expenses following the payment of the annual high deductible plan
13 F deductible. The covered expenses include the core benefit, plus
14 the Medicare Part A deductible, skilled nursing facility care, the
15 Medicare Part B deductible, 100 percent of the Medicare Part B
16 excess charges, and medically necessary emergency care in a
17 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
18 of subdivision (c) of Section 10192.8, respectively. The annual
19 high deductible plan F deductible shall consist of out-of-pocket
20 expenses, other than premiums, for services covered by the
21 Medicare supplement plan F policy, and shall be in addition to any
22 other specific benefit deductibles. The annual high deductible Plan
23 F deductible shall be one thousand five hundred dollars (\$1,500)
24 for 1998 and 1999, and shall be based on the calendar year, as
25 adjusted annually thereafter by the secretary to reflect the change
26 in the Consumer Price Index for all urban consumers for the
27 12-month period ending with August of the preceding year, and
28 rounded to the nearest multiple of ten dollars (\$10).

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

36 (9) Standardized Medicare supplement benefit plan H shall
37 consist of only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, basic outpatient
39 prescription drug benefit, and medically necessary emergency care
40 in a foreign country as defined in paragraphs (1), (2), (6), and (8)

1 of subdivision (c) of Section 10192.8, respectively. The outpatient
2 prescription drug benefit shall not be included in a Medicare
3 supplement policy sold on or after January 1, 2006.

4 (10) Standardized Medicare supplement benefit plan I shall
5 consist of only the following: the core benefit, plus the Medicare
6 Part A deductible, skilled nursing facility care, 100 percent of the
7 Medicare Part B excess charges, basic outpatient prescription drug
8 benefit, medically necessary emergency care in a foreign country,
9 and at-home recovery benefit as defined in paragraphs (1), (2),
10 (5), (6), (8), and (10) of subdivision (c) of Section 10192.8,
11 respectively. The outpatient prescription drug benefit shall not be
12 included in a Medicare supplement policy sold on or after January
13 1, 2006.

14 (11) Standardized Medicare supplement benefit plan J shall
15 consist of only the following: the core benefit, plus the Medicare
16 Part A deductible, skilled nursing facility care, Medicare Part B
17 deductible, 100 percent of the Medicare Part B excess charges,
18 extended outpatient prescription drug benefit, medically necessary
19 emergency care in a foreign country, preventive medical care, and
20 at-home recovery benefit as defined in paragraphs (1), (2), (3),
21 (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8,
22 respectively. The outpatient prescription drug benefit shall not be
23 included in a Medicare supplement policy sold on or after January
24 1, 2006.

25 (12) Standardized Medicare supplement benefit high deductible
26 plan J shall consist of only the following: 100 percent of covered
27 expenses following the payment of the annual high deductible plan
28 J deductible. The covered expenses include the core benefit, plus
29 the Medicare Part A deductible, skilled nursing facility care,
30 Medicare Part B deductible, 100 percent of the Medicare Part B
31 excess charges, extended outpatient prescription drug benefit,
32 medically necessary emergency care in a foreign country,
33 preventive medical care benefit, and at-home recovery benefit as
34 defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of
35 subdivision (c) of Section 10192.8, respectively. The annual high
36 deductible plan J deductible shall consist of out-of-pocket expenses,
37 other than premiums, for services covered by the Medicare
38 supplement plan J policy, and shall be in addition to any other
39 specific benefit deductibles. The annual deductible shall be one
40 thousand five hundred dollars (\$1,500) for 1998 and 1999, and

1 shall be based on a calendar year, as adjusted annually thereafter
2 by the secretary to reflect the change in the Consumer Price Index
3 for all urban consumers for the 12-month period ending with
4 August of the preceding year, and rounded to the nearest multiple
5 of ten dollars (\$10). The outpatient prescription drug benefit shall
6 not be included in a Medicare supplement policy sold on or after
7 January 1, 2006.

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

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

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

24 ~~SEC. 20.~~

25 *SEC. 21.* Section 10192.91 is added to the Insurance Code, to
26 read:

27 10192.91. The following standards are applicable to all
28 Medicare supplement policies or certificates delivered or issued
29 for delivery in this state with an effective date on or after June 1,
30 2010. No policy or certificate may be advertised, solicited,
31 delivered, or issued for delivery in this state as a Medicare
32 supplement policy or certificate unless it complies with these
33 benefit plan standards. Benefit plan standards applicable to
34 Medicare supplement policies and certificates issued with an
35 effective date before June 1, 2010, remain subject to the
36 requirements of Section 10192.9.

37 (a) (1) An issuer shall make available to each prospective
38 policyholder and certificate holder a policy form or certificate form
39 containing only the basic (core) benefits, as defined in subdivision
40 (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), 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

1 percent of the Medicare Part B deductible, and medically necessary
2 emergency care in a foreign country, as defined in paragraphs (1),
3 (3), (4), and (6) of subdivision (c) of Section 10192.81,
4 respectively.

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

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

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

24 (A) The covered expenses include the basic (core) benefit as
25 defined in subdivision (b) of Section 10192.81, plus 100 percent
26 of the Medicare Part A deductible, skilled nursing facility care,
27 100 percent of the Medicare Part B deductible, 100 percent of the
28 Medicare Part B excess charges, and medically necessary
29 emergency care in a foreign country, as defined in paragraphs (1),
30 (3), (4), (5), and (6) of subdivision (c) of Section 10192.81,
31 respectively.

32 (B) The annual deductible in Plan F with high deductible shall
33 consist of out-of-pocket expenses, other than premiums, for
34 services covered by Plan F, and shall be in addition to any other
35 specific benefit deductibles. The basis for the deductible shall be
36 one thousand five hundred dollars (\$1,500) and shall be adjusted
37 annually from 1999 by the Secretary of the United States
38 Department of Health and Human Services to reflect the change
39 in the Consumer Price Index for all urban consumers for the

1 12-month period ending with August of the preceding year, and
2 rounded to the nearest multiple of ten dollars (\$10).

3 (7) Standardized Medicare supplement benefit Plan G shall
4 include only the following: the basic (core) benefit as defined in
5 subdivision (b) of Section 10192.81, plus 100 percent of the
6 Medicare Part A deductible, skilled nursing facility care, 100
7 percent of the Medicare Part B excess charges, and medically
8 necessary emergency care in a foreign country, as defined in
9 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section
10 10192.81, respectively.

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

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

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

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

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

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

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

38 (G) Coverage for 50 percent, under Medicare Part A or B, of
39 the reasonable cost of the first three pints of blood, or equivalent
40 quantities of packed red blood cells, as defined under federal

1 regulations, unless replaced in accordance with federal regulations
2 until the out-of-pocket limitation is met as described in
3 subparagraph (J).

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

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

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

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

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

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

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

28 (10) Standardized Medicare supplement Plan M shall include
29 only the following: the basic (core) benefit as defined in
30 subdivision (b) of Section 10192.81, plus 50 percent of the
31 Medicare Part A deductible, skilled nursing facility care, and
32 medically necessary emergency care in a foreign country, as
33 defined in paragraphs (2), (3), and (6) of subdivision (c) of Section
34 10192.81, respectively.

35 (11) Standardized Medicare supplement Plan N shall include
36 only the following: the basic (core) benefit as defined in
37 subdivision (b) of Section 10192.81, plus 100 percent of the
38 Medicare Part A deductible, skilled nursing facility care, and
39 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. 21.~~

SEC. 22. 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

1 six months after the date of his or her enrollment in Medicare Part
2 B, or if notified retroactively of his or her eligibility for Medicare,
3 for six months following notice of eligibility. Every issuer shall
4 make available to every applicant qualified for open enrollment
5 all policies and certificates offered by that issuer at the time of
6 application. Issuers shall not discourage sales during the open
7 enrollment period by any means, including the altering of the
8 commission structure.

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

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

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

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

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

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

38 (g) An individual whose coverage was terminated by a Medicare
39 Advantage plan shall be entitled to an additional 60-day open
40 enrollment period to be added on to and run consecutively after

1 any open enrollment period authorized by federal law or regulation,
2 for any Medicare supplement coverage provided by Medicare
3 supplement issuers and available on a guaranteed basis under state
4 and federal law or regulation for persons terminated by their
5 Medicare Advantage plan.

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

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

26 ~~SEC. 22:~~

27 *SEC. 23.* Section 10192.12 of the Insurance Code is amended
28 to read:

29 10192.12. (a) (1) With respect to the guaranteed issue of a
30 Medicare supplement policy, eligible persons are those individuals
31 described in subdivision (b) who seek to enroll under the policy
32 during the period specified in subdivision (c), and who submit
33 evidence of the date of termination or disenrollment or enrollment
34 in Medicare Part D with the application for a Medicare supplement
35 policy.

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

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

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

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

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

8 (1) The individual is enrolled under an employee welfare benefit
9 plan that provides health benefits that supplement the benefits
10 under Medicare, the plan either terminates or ceases to provide all
11 of those supplemental health benefits to the individual, and the
12 employer no longer provides the individual with insurance that
13 covers all of the payment for the 20-percent coinsurance.

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

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

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

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

30 (D) The Medicare Advantage plan in which the individual is
31 enrolled reduces any of its benefits or increases the amount of cost
32 sharing or discontinues for other than good cause relating to quality
33 of care, its relationship or contract under the plan with a provider
34 who is currently furnishing services to the individual. An individual
35 shall be eligible under this subparagraph for a Medicare supplement
36 policy issued by the same issuer through which the individual was
37 enrolled at the time the reduction, increase, or discontinuance
38 described above occurs or, commencing January 1, 2007, for one
39 issued by a subsidiary of the parent company of that issuer or by
40 a network that contracts with the parent company of that issuer.

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

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

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

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

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

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

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

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

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

26 (iii) An organization under an agreement under Section
27 1833(a)(1)(A) of the Social Security Act (health care prepayment
28 plan).

29 (iv) An organization under a Medicare Select policy.

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

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

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

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

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

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

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

14 (B) The subsequent enrollment under subparagraph (A) is
15 terminated by the individual during any period within the first 12
16 months of the subsequent enrollment (during which the enrollee
17 is permitted to terminate the subsequent enrollment under Section
18 1851(e) of the federal Social Security Act).

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

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

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

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

40 (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

1 Plan F), K, or L and that is offered and is available for issuance to
2 a new enrollee by the same issuer that issued the individual's
3 Medicare supplement policy with outpatient prescription drug
4 coverage.

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

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

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

28 ~~SEC. 23.~~

29 *SEC. 24.* Section 10192.13 of the Insurance Code is amended
30 to read:

31 10192.13. (a) An issuer shall comply with Section 1882(c)(3)
32 of the federal Social Security Act (as enacted by Section
33 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
34 of 1987 (OBRA), Public Law 100-203) by doing all of the
35 following and by certifying compliance on the Medicare
36 supplement insurance experience reporting form:

37 (1) Accepting a notice from a Medicare Administrative
38 Contractor, formerly known as a fiscal intermediary or carrier, on
39 dually assigned claims submitted by participating physicians and
40 suppliers as a claim for benefits in place of any other claim form

1 otherwise required and making a payment determination on the
2 basis of the information contained in that notice.

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

5 (3) Paying the participating physician or supplier directly.

6 (4) Furnishing, at the time of enrollment, each enrollee with a
7 card listing the policy name, number, and a central mailing address
8 to which notices from a Medicare Administrative Contractors may
9 be sent.

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

12 (6) Providing to the secretary, at least annually, a central mailing
13 address to which all claims may be sent by Medicare
14 Administrative Contractors.

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

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

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

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

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

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

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

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

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

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

1 ~~SEC. 24.~~

2 *SEC. 25.* Section 10192.17 of the Insurance Code is amended
3 to read:

4 10192.17. (a) Medicare supplement policies and certificates
5 shall include a renewal, continuation, or conversion provision. The
6 language or specifications of the provision shall be consistent with
7 the type of contract issued. The provision shall be appropriately
8 captioned and shall appear on the first page of the policy, and shall
9 include any reservation by the issuer of the right to change
10 premiums and any automatic renewal premium increases based
11 on the policyholder's age.

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

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

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

37 (e) (1) Medicare supplement policies and certificates shall have
38 a notice prominently printed on the first page of the policy or
39 certificate, and of the outline of coverage, or attached thereto, in
40 no less than 10-point uppercase type, stating in substance that the

1 policyholder or certificate holder shall have the right to return the
2 policy or certificate, via regular mail, within 30 days of receiving
3 it, and to have the full premium refunded if, after examination of
4 the policy or certificate, the insured person is not satisfied for any
5 reason. The return shall void the contract from the beginning, and
6 the parties shall be in the same position as if no contract had been
7 issued.

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

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

16 (f) (1) Issuers of health insurance policies, certificates, or
17 contracts that provide hospital or medical expense coverage on an
18 expense incurred or indemnity basis, other than incidentally, to
19 persons eligible for Medicare shall provide to those applicants a
20 Guide to Health Insurance for People with Medicare in the form
21 developed jointly by the National Association of Insurance
22 Commissioners and the Centers for Medicare and Medicaid
23 Services and in a type size no smaller than 12-point type. Delivery
24 of the guide shall be made whether or not the policies or certificates
25 are advertised, solicited, or issued for delivery as Medicare
26 supplement policies or certificates as defined in this article. Except
27 in the case of direct response issuers, delivery of the guide shall
28 be made to the applicant at the time of application, and
29 acknowledgment of receipt of the guide shall be obtained by the
30 issuer. Direct response issuers shall deliver the guide to the
31 applicant upon request, but not later than at the time the policy is
32 delivered.

33 (2) For the purposes of this section, “form” means the language,
34 format, type size, type proportional spacing, bold character, and
35 line spacing.

36 (g) As soon as practicable, but no later than 30 days prior to the
37 annual effective date of any Medicare benefit changes, an issuer
38 shall notify its policyholders and certificate holders of
39 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 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

1 all plans that are offered to the prospective applicant. All possible
2 premiums for the prospective applicant shall be illustrated.

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

8 (k) (1) Any disability insurance policy or certificate, a basic,
9 catastrophic or major medical expense policy, or single premium
10 nonrenewal policy or certificate issued to persons eligible for
11 Medicare, other than a Medicare supplement policy, a policy issued
12 pursuant to a contract under Section 1876 of the federal Social
13 Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income
14 policy, or any other policy identified in subdivision (b) of Section
15 10192.3, advertised, solicited, or issued for delivery in this state
16 to persons eligible for Medicare, shall notify insureds under the
17 policy that the policy is not a Medicare supplement policy or
18 certificate. The notice shall either be printed or attached to the first
19 page of the outline of coverage delivered to insureds under the
20 policy, or if no outline of coverage is delivered, to the first page
21 of the policy or certificate delivered to insureds. The notice shall
22 be in no less than 12-point type and shall contain the following
23 language:

24
25 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE
26 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible
27 for Medicare, review the Guide to Health Insurance for People
28 with Medicare available from the company.”
29

30 (2) Applications provided to persons eligible for Medicare for
31 the disability insurance policies or certificates described in
32 paragraph (1) shall disclose the extent to which the policy
33 duplicates Medicare in a manner required by the commissioner.
34 The disclosure statement shall be provided as a part of, or together
35 with, the application for the policy or certificate.

36 (l) (1) Insurers issuing Medicare supplement policies or
37 certificates for delivery in California shall provide an outline of
38 coverage to all applicants at the time of presentation for
39 examination or sale as provided in Section 10605, and in no case
40 later than at the time the application is made. Except for direct

1 response policies, insurers shall obtain a written acknowledgment
2 of receipt of the outline from the applicant.

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

10 (2) If an outline of coverage is provided at or before the time
11 of application and the Medicare supplement policy or certificate
12 is issued on a basis that would require revision of the outline, a
13 substitute outline of coverage properly describing the policy or
14 certificate shall accompany the policy or certificate when it is
15 delivered and contain the following statement, in no less than
16 12-point type, immediately above the name:

17
18 “NOTICE: Read this outline of coverage carefully. It is not
19 identical to the outline of coverage provided upon application and
20 the coverage originally applied for has not been issued.”

21
22 (3) The outline of coverage shall be in the language and format
23 prescribed in this subdivision in no less than 12-point type, and
24 shall include the following items in the order prescribed below.
25 Titles, as set forth below in paragraphs (B) to (H), inclusive, shall
26 be capitalized, centered, and printed in boldface type.

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

29 (I) The outline of coverage shall include the items, and in the
30 same order, specified in the chart set forth in Section 17 of the
31 Model Regulation to implement the NAIC Medicare Supplement
32 Insurance Minimum Standards Model Act, as adopted by the
33 National Association of Insurance Commissioners in 2004.

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

38
39 “Medicare supplement insurance can be sold in only 12 standard
40 plans. This chart shows the benefits included in each plan. Every

1 insurance company must offer Plan A. Some plans may not be
2 available.

3 The BASIC BENEFITS included in ALL plans are:

4 Hospitalization: Medicare Part A coinsurance plus coverage for
5 365 additional days after Medicare benefits end.

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

8 Blood: First three pints of blood each year.

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

11 Cervical cancer test: One annual screening.”

12
13 [Reference to the mammogram and cervical cancer screening
14 test shall not be included so long as California is required to
15 disallow them for Medicare beneficiaries by the Centers for
16 Medicare and Medicaid Services or other agent of the federal
17 government under 42 U.S.C. Sec. 1395ss.]

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

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

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

30
31 “Medicare supplement insurance can be sold in only standard
32 plans. This chart shows the benefits included in each plan. Every
33 insurance company must offer Plan A. Some plans may not be
34 available. Plans E, H, I and J are no longer available for sale. [This
35 sentence shall not appear after June 1, 2011.]

36 The BASIC BENEFITS included in ALL plans are:

37 Hospitalization: Medicare Part A coinsurance plus coverage for
38 365 additional days after Medicare benefits end.

39 Medical expenses: Medicare Part B coinsurance (usually 20
40 percent of the Medicare-approved amount) or copayments for

1 hospital outpatient services. Plans K, L, and N require insureds to
2 pay a portion of Part B coinsurance copayments.

3 Blood: First three pints of blood each year.

4 Hospice: Part A coinsurance.

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

7 Cervical cancer test: One annual screening.”

8
9 [Reference to the mammogram and cervical cancer screening
10 test shall not be included so long as California is required to
11 disallow them for Medicare beneficiaries by the Centers for
12 Medicare and Medicaid Services or other agent of the federal
13 government under 42 U.S.C. Sec. 1395ss.]

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

25 (C) The text shall state: “Use this outline to compare benefits
26 and premiums among policies.”

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

32 (E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The
33 text shall state: “If you find that you are not satisfied with your
34 policy, you may return it to [insert the insurer’s address]. If you
35 send the policy back to us within 30 days after you receive it, we
36 will treat the policy as if it has never been issued and return all of
37 your payments.”

38 (F) POLICY REPLACEMENT. The text shall read: “If you are
39 replacing another health insurance policy, do NOT cancel it until

1 you have actually received your new policy and are sure you want
2 to keep it.”

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

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

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

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

29 (I) One chart for each benefit plan offered by the insurer
30 showing the services, Medicare payments, payments under the
31 policy and payments expected from the insured, using the same
32 uniform format and language. No more than four plans may be
33 shown on one page. Include an explanation of any innovative
34 benefits in a manner approved by the commissioner.

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

38 ~~SEC. 25.~~

39 SEC. 26. Section 10192.18 of the Insurance Code is amended
40 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

1 NOTE TO APPLICANT: If you have a share of cost under the
2 Medi-Cal program, please answer NO to this question.
3 Yes____ No____
4 If yes,
5 (a) Will Medi-Cal pay your premiums for this Medicare
6 supplement policy
7 Yes____ No____
8 (b) Do you receive benefits from Medi-Cal OTHER THAN
9 payments toward your Medicare Part B premium
10 Yes____ No____
11 (3) (a) If you had coverage from any Medicare plan other than
12 original Medicare within the past 63 days (for example, a Medicare
13 Advantage plan or a Medicare HMO or PPO), fill in your start and
14 end dates below. If you are still covered under this plan, leave
15 "END" blank.
16 START __/__/__ END __/__/__
17 (b) If you are still covered under the Medicare plan, do you
18 intend to replace your current coverage with this new Medicare
19 supplement policy
20 Yes____ No____
21 (c) Was this your first time in this type of Medicare plan
22 Yes____ No____
23 (d) Did you drop a Medicare supplement policy to enroll in the
24 Medicare plan
25 Yes____ No____
26 (4) (a) Do you have another Medicare supplement policy in
27 force
28 Yes____ No____
29 (b) If so, with what company, and what plan do you have
30 [optional for direct mailers]
31 Yes____ No____
32 (c) If so, do you intend to replace your current Medicare
33 supplement policy with this policy
34 Yes____ No____
35 (5) Have you had coverage under any other health insurance
36 within the past 63 days (For example, an employer, union, or
37 individual plan)
38 Yes____ No____
39 (a) If so, with what companies and what kind of policy
40 _____

1 _____
2 _____
3 _____
4 (b) What are your dates of coverage under the other policy
5 START __/__/__ END __/__/__
6 (If you are still covered under the other policy, leave “END”
7 blank.)

8
9 (b) Agents shall list any other health insurance policies they
10 have sold to the applicant as follows:

- 11 (1) List policies sold that are still in force.
12 (2) List policies sold in the past five years that are no longer in
13 force.

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

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

30 (e) The notice required by subdivision ~~(e)~~ (d) for an issuer shall
31 be in the form specified by the commissioner, using, to the extent
32 practicable, a model notice prepared by the National Association
33 of Insurance Commissioners for this purpose. The replacement
34 notice shall be printed in no less than 12-point type in substantially
35 the following form:

1 [Insurer's name and address]

2
3 NOTICE TO APPLICANT REGARDING REPLACEMENT
4 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
5 ADVANTAGE
6

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

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

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

20 If you want to discuss buying Medicare supplement or Medicare
21 Advantage coverage with a trained insurance counselor, call the
22 California Department of Insurance's toll-free telephone number
23 1-800-927-HELP, and ask how to contact your local Health
24 Insurance Counseling and Advocacy Program (HICAP) office.
25 HICAP is a service provided free of charge by the State of
26 California.

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

- 36 ___ Additional benefits that are: _____
37 ___ No change in benefits, but lower premiums.
38 ___ Fewer benefits and lower premiums.
39 ___ Plan has outpatient prescription drug coverage and applicant
40 is enrolled in Medicare Part D.

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

___ Other reasons specified here: _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not *impose*, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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

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

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

(Signature of Agent, Broker, or Other Representative)

(Signature of Applicant)

(Date)

1
2 (f) No issuer, broker, agent, or other person shall cause an
3 insured to replace a Medicare supplement insurance policy
4 unnecessarily. In recommending replacement of any Medicare
5 supplement insurance, an agent shall make reasonable efforts to
6 determine the appropriateness to the potential insured.

7 (g) For an individual who is subject to an open enrollment period
8 or who is guaranteed-issue issuance of any Medicare supplement
9 coverage as described in Section 10192.11 or 10192.12, an issuer
10 shall not *require or use*, for the purpose of determining eligibility
11 *or premium levels, or for any other purpose not explicitly disclosed*
12 *to the applicant pursuant to this subdivision*, the applicant's health
13 information, including health information acquired in compliance
14 with the federal Health Insurance Portability and Accountability
15 Act of 1996, *or require an applicant to sign a form required by*
16 *the federal Health Insurance Portability and Accountability Act*
17 *of 1996. A statement of this prohibition shall be included on the*
18 *application form in clear and conspicuous language, in addition*
19 *to the open enrollment and guaranteed issue periods described in*
20 *Section 10192.11 or Sections 10192.11 and 10192.12. This*
21 *subdivision shall not prohibit an issuer from requiring proof of*
22 *eligibility for a guaranteed issuance of Medicare supplement*
23 *coverage. This subdivision shall not preclude an issuer from*
24 *requesting an applicant to voluntarily provide health information,*
25 *provided that the issuer obtains authorization in compliance with*
26 *the applicable requirements under the federal Health Insurance*
27 *Portability and Accountability Act of 1996.*

28 ~~SEC. 26.~~

29 SEC. 27. Section 10192.20 of the Insurance Code is amended
30 to read:

31 10192.20. (a) An issuer, directly or through its producers, shall
32 do each of the following:

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

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

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

40

1 “Notice to buyer: This policy may not cover all of your medical
2 expenses.”

3
4 (4) Inquire and otherwise make every reasonable effort to
5 identify whether a prospective applicant for a Medicare supplement
6 policy already has health insurance and the types and amounts of
7 that insurance.

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

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

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

18 (2) High pressure tactics, which means employing any method
19 of marketing having the effect of or tending to induce the purchase
20 of insurance through force, fright, threat, whether explicit or
21 implied, or undue pressure to purchase or recommend the purchase
22 of insurance.

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

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

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

38 (1) (A) For policies sold for effective dates prior to June 1,
39 2010, a listing of all the policies, plans A to L, inclusive, that are
40 available from the company.

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

5 (2) (A) For policies sold for effective dates prior to June 1,
6 2010, a listing of all the policies, plans A to L, inclusive, for
7 Medicare beneficiaries under the age of 65 that are available from
8 the company.

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

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

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

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

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

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

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

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

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

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

1 Department of Insurance's Internet Web site
2 (www.insurance.ca.gov)."

3 ~~SEC. 27.~~

4 *SEC. 28.* Section 10192.24 is added to the Insurance Code, to
5 read:

6 10192.24. This section applies to all policies with policy years
7 beginning on or after May 21, 2009.

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

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

18 (2) The issuer shall not discriminate in the pricing of the policy
19 or certificate, including the adjustment of premium rates, of an
20 individual on the basis of the genetic information with respect to
21 that individual or a family member of the individual.

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

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

28 (2) Increase the premium for any policy issued to an individual
29 based on the manifestation of a disease or disorder of an individual
30 who is covered under the policy. For purposes of this paragraph,
31 the manifestation of a disease or disorder in one individual shall
32 not also be used as genetic information about other group members
33 and to further increase the premium for the group.

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

37 (d) Subdivision (c) shall not be construed to preclude an issuer
38 of a Medicare supplement policy or certificate from obtaining and
39 using the results of a genetic test in making a determination
40 regarding payment, as defined for the purposes of applying the

1 regulations promulgated under Part C of Title XI and Section 264
2 of the Health Insurance Portability and Accountability Act of 1996,
3 as may be revised from time to time, and consistent with
4 subdivision (a).

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

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

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

17 (h) If an issuer of a Medicare supplement policy or certificate
18 obtains genetic information incidental to the requesting, requiring,
19 or purchasing of other information concerning any individual or
20 a family member of that individual, the request, requirement, or
21 purchase shall not be considered a violation of subdivision (g) if
22 the request, requirement, or purchase is not in violation of
23 subdivision (f). However, the issuer shall not use any genetic
24 information obtained under this section for any prohibited purpose
25 described in this section or in Sections 10140 and 10143.

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

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

31 (2) "Family member" means, with respect to an individual, any
32 other individual who is a first-degree, second-degree, third-degree,
33 or fourth-degree relative of the individual.

34 (3) "Genetic information" means, with respect to any individual,
35 information about the individual's genetic tests, the genetic tests
36 of family members of the individual, and the manifestation of a
37 disease or disorder in family members of the individual. The term
38 includes, with respect to any individual, any request for, or receipt
39 of, genetic services, or participation in clinical research that
40 includes genetic services, by the individual or any family member

1 of the individual. Any reference to genetic information concerning
2 an individual or family member of an individual who is a pregnant
3 woman includes genetic information of any fetus carried by that
4 pregnant woman, or with respect to an individual or family member
5 utilizing reproductive technology, includes genetic information of
6 any embryo legally held by an individual or family member. The
7 term “genetic information” does not include information about the
8 sex or age of any individual.

9 (4) “Genetic services” means a genetic test, genetic education,
10 or genetic counseling, including obtaining, interpreting, or
11 assessing genetic information.

12 (5) “Genetic test” means an analysis of human DNA, RNA,
13 chromosomes, proteins, or metabolites, that detect genotypes,
14 mutations, or chromosomal changes. The term “genetic test” does
15 not mean an analysis of proteins or metabolites that does not detect
16 genotypes, mutations, or chromosomal changes; or an analysis of
17 proteins or metabolites that is directly related to a manifested
18 disease, disorder, or pathological condition that could reasonably
19 be detected by a health care professional with appropriate training
20 and expertise in the field of medicine involved.

21 (6) “Underwriting purposes” includes all of the following:

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

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

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

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

30 ~~SEC. 28.~~

31 *SEC. 29.* No reimbursement is required by this act pursuant to
32 Section 6 of Article XIII B of the California Constitution because
33 the only costs that may be incurred by a local agency or school
34 district will be incurred because this act creates a new crime or
35 infraction, eliminates a crime or infraction, or changes the penalty
36 for a crime or infraction, within the meaning of Section 17556 of
37 the Government Code, or changes the definition of a crime within
38 the meaning of Section 6 of Article XIII B of the California
39 Constitution.

1 ~~SEC. 29.~~

2 *SEC. 30.* This act is an urgency statute necessary for the
3 immediate preservation of the public peace, health, or safety within
4 the meaning of Article IV of the Constitution and shall go into
5 immediate effect. The facts constituting the necessity are:

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