

AMENDED IN ASSEMBLY MAY 21, 2009

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.~~ *Advantage plans.*

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 entitles individuals to an annual open enrollment period, commencing with the individual's birthday, during which time the individual may purchase any Medicare supplement contract or policy that offers benefits equal to or lesser than those provided by the previous coverage, as specified.

This bill would identify the Medicare supplement plans, based on the modernization changes described above, that provide equal coverage for purposes of this provision.

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~~

~~This bill would also require that provide that a person is eligible for the guaranteed issue of a Medicare supplement plan if the person is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, the plan either terminates or ceases to provide all of those supplemental health benefits,~~

and the employer no longer ~~provide~~ provides 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.~~

This bill would extend those prohibitions to an applicant who is subject to an open enrollment period, as specified.

Existing law provides for the federal Medicare Program, which provides health care benefits, including prescription drug benefits, to persons 65 years of age 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 an entity that arranges to provide undertakes to arrange for the provision of 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.

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~~ *An entity that undertakes to arrange for*
5 *the provision of* health care services in this state under the Medicare
6 Advantage program pursuant to Part C (commencing with Section
7 1395w-21) of Title XVIII of Chapter 7 of Title 42 of the United
8 States Code shall be licensed under this chapter and shall comply
9 with all requirements under this chapter except to the extent
10 preempted by federal law.

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

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

16 1358.4. The following definitions apply for the purposes of
17 this article:

18 (a) "Applicant" means:

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

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

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

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

1 (d) (1) “Creditable coverage” means, with respect to an
2 individual, coverage of the individual provided under any of the
3 following:

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

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

13 (C) Title XIX of the federal Social Security Act (medicaid),
14 other than coverage consisting solely of benefits under Section
15 1928 of that act.

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

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

20 (F) A state health benefits risk pool.

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

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

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

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

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

34 (2) “Creditable coverage” shall not include one or more, or any
35 combination of, the following:

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

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

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

1 (D) Workers' compensation or similar insurance.

2 (E) Automobile medical payment insurance.

3 (F) Credit-only insurance.

4 (G) Coverage for onsite medical clinics.

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

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

11 (A) Limited scope dental or vision benefits.

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

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

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

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

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

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

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

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

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

28 (e) "Employee welfare benefit plan" means a plan, fund, or
29 program of employee benefits as defined in Section 1002 of Title
30 29 of the United States Code (Employee Retirement Income
31 Security Act).

32 (f) "Insolvency" means when an issuer, licensed to transact the
33 business of a health care service plan in this state, has had a final
34 order of liquidation entered against it with a finding of insolvency
35 by a court of competent jurisdiction in the issuer's state of domicile.

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

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

4 (i) “Medicare Advantage Plan” means a plan of coverage for
5 health benefits under Medicare Part C and includes:

6 (1) Coordinated care plans that provide health care services,
7 including, but not limited to, health care service plans (with or
8 without a point-of-service option), plans offered by
9 provider-sponsored organizations, and preferred provider
10 organizations plans.

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

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

14 (j) “Medicare supplement contract” means a group or individual
15 plan contract of hospital and medical service associations or health
16 care service plans, other than a contract issued pursuant to a
17 contract under Section 1876 of the federal Social Security Act (42
18 U.S.C.A. Section 1395mm) or an issued contract under a
19 demonstration project specified in Section 1395ss(g)(1) of Title
20 42 of the United States Code, that is advertised, marketed, or
21 designed primarily as a supplement to reimbursements under
22 Medicare for the hospital, medical, or surgical expenses of persons
23 eligible for Medicare. “Contract” means “Medicare supplement
24 contract,” unless the context requires otherwise. “Medicare
25 supplement contract” does not include a Medicare Advantage plan
26 established under Medicare Part C, an outpatient prescription drug
27 plan established under Medicare Part D, or a health care
28 prepayment plan that provides benefits pursuant to an agreement
29 under subparagraph (A) of paragraph (1) of subsection (a) of
30 Section 1833 of the Social Security Act.

31 ~~(k) “Prestandardized Medicare supplement benefit plan,”~~
32 ~~“prestandardized benefit plan,” or “prestandardized plan” means~~
33 ~~a group or individual Medicare supplement contract issued prior~~
34 ~~to July 21, 1992.~~

35 ~~(l)~~
36 (k) “1990 standardized Medicare supplement benefit plan,”
37 “1990 standardized benefit plan,” or “1990 plan” means a group
38 or individual Medicare supplement contract issued on or after July
39 21, 1992, and with an effective date prior to June 1, 2010, and
40 includes Medicare supplement contracts renewed on or after that

1 date that are not replaced by the issuer at the request of the enrollee
2 or subscriber.

3 ~~(m)~~

4 (l) “2010 standardized Medicare supplement benefit plan,”
5 “2010 standardized benefit plan,” or “2010 plan” means a group
6 or individual Medicare supplement contract issued with an effective
7 date on or after June 1, 2010.

8 ~~(n)~~

9 (m) “Secretary” means the Secretary of the United States
10 Department of Health and Human Services.

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

13 1358.6. (a) (1) Except for permitted preexisting condition
14 clauses as described in Sections 1358.7, 1358.8, and 1358.81, a
15 contract shall not be advertised, solicited, or issued for delivery
16 as a Medicare supplement contract if the contract contains
17 definitions, limitations, exclusions, conditions, reductions, or other
18 provisions that are more restrictive or limiting than that term as
19 officially used in Medicare, except as expressly authorized by this
20 article.

21 (2) No issuer may advertise, solicit, or issue for delivery any
22 Medicare supplement contract with hospital or medical coverage
23 if the contract contains any of the prohibited provisions described
24 in subdivision (b).

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

28 (1) Any waiver, exclusion, limitation, or reduction based on or
29 relating to a preexisting disease or physical condition, unless that
30 waiver, exclusion, limitation, or reduction (A) applies only to
31 coverage for specified services rendered not more than six months
32 from the effective date of coverage, (B) is based on or relates only
33 to a preexisting disease or physical condition defined no more
34 restrictively than a condition for which medical advice was given
35 or treatment was recommended by or received from a physician
36 within six months before the effective date of coverage, (C) does
37 not apply to any coverage under any group contract, and (D) is
38 approved in advance by the director. Any limitations with respect
39 to a preexisting condition shall appear as a separate paragraph of
40 the contract and be labeled “Preexisting Condition Limitations.”

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

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

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

(2) A Medicare supplement contract 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 contract with benefits for outpatient prescription drugs shall not be renewed after the enrollee or subscriber enrolls in Medicare Part D unless both of the following conditions exist:

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

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

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

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

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

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

8 (2) A Medicare supplement contract shall not indemnify against
9 losses resulting from sickness on a different basis than losses
10 resulting from accidents.

11 (3) A Medicare supplement contract shall provide that benefits
12 designed to cover cost-sharing amounts under Medicare will be
13 changed automatically to coincide with any changes in the
14 applicable Medicare deductible, copayment, or coinsurance
15 amounts. Prepaid or periodic charges may be modified to
16 correspond with those changes.

17 (4) A Medicare supplement contract shall not provide for
18 termination of coverage of a spouse solely because of the
19 occurrence of an event specified for termination of coverage of
20 the covered person, other than the nonpayment of the prepaid or
21 periodic charge.

22 (5) Each Medicare supplement contract shall be guaranteed
23 renewable.

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

26 (B) The issuer shall not cancel or nonrenew the contract for any
27 reason other than nonpayment of the prepaid or periodic charge
28 or misrepresentation of the risk by the applicant that is shown by
29 the plan to be material to the acceptance for coverage. The
30 contestability period for Medicare supplement contracts shall be
31 two years.

32 (C) If a group Medicare supplement contract is terminated by
33 the subscriber and is not replaced as provided under subparagraph
34 (E), the issuer shall offer enrollees an individual Medicare
35 supplement contract that, at the option of the enrollee, either
36 provides for continuation of the benefits contained in the terminated
37 contract or provides for benefits that otherwise meet the
38 requirements of this subsection.

39 (D) If an individual is an enrollee in a group Medicare
40 supplement contract and the individual membership in the group

1 is terminated, the issuer shall either offer the enrollee the
2 conversion opportunity described in subparagraph (C) or, at the
3 option of the subscriber, shall offer the enrollee continuation of
4 coverage under the group contract.

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

12 (F) If a Medicare supplement contract eliminates an outpatient
13 prescription drug benefit as a result of requirements imposed by
14 the Medicare Prescription Drug, Improvement, and Modernization
15 Act of 2003 (Public Law 108-173), the contract as modified as a
16 result of that act shall be deemed to satisfy the guaranteed renewal
17 requirements of this paragraph.

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

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

34 If suspension occurs and if the enrollee loses entitlement to
35 medical assistance, the contract shall be automatically ~~reinstated,~~
36 ~~effective reinstated~~ *(effective as of the date of termination of*
37 ~~entitlement, entitlement)~~ *entitlement)* as of the termination of entitlement if the
38 enrollee provides notice of loss of entitlement within 90 days after
39 the date of loss and pays the prepaid or periodic charge attributable
40 to the period, effective as of the date of termination of entitlement.

1 Upon receipt of timely notice, the issuer shall return directly to
2 the enrollee that portion of the prepaid or periodic charge
3 attributable to the period the enrollee was entitled to medical
4 assistance, subject to adjustment for paid claims.

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

16 (B) Reinstitution of coverages:

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

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

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

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

37 (A) An issuer need not provide justification to the director if
38 the enrollee or subscriber replaces a 1990 standardized plan
39 contract with an issue age rated 2010 standardized plan contract
40 at the enrollee or subscriber's original issue age and duration. If

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

8 (B) The rating class of the new plan contract shall be the class
9 closest to the enrollee or subscriber's class of the replaced
10 coverage.

11 (C) An issuer may not apply new preexisting condition
12 limitations or a new incontestability period to the new plan contract
13 for those benefits contained in the exchanged 1990 standardized
14 plan contract of the enrollee or subscriber, but may apply
15 preexisting condition limitations of no more than six months to
16 any added benefits contained in the new 2010 standardized plan
17 contract not contained in the exchanged plan contract. This
18 subdivision shall not apply to an applicant who is guaranteed issue
19 under Section 1358.11 or 1358.12.

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

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

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

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

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

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

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

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

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

13 (b) With respect to the standards for basic (core) benefits for
14 benefit plans A to J, inclusive, every issuer shall make available
15 a contract including only the following basic “core” package of
16 benefits to each prospective applicant. This “core” package of
17 benefits shall be referred to as standardized Medicare supplement
18 benefit plan “A”. An issuer may make available to prospective
19 applicants any of the other Medicare supplement benefit plans in
20 addition to the basic core package, but not in lieu of that package.

21 (1) Coverage of Part A Medicare eligible expenses for
22 hospitalization to the extent not covered by Medicare from the
23 61st day to the 90th day, inclusive, in any Medicare benefit period.

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

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

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

39 (5) Coverage for the coinsurance amount, or in the case of
40 hospital outpatient services, the copayment amount, of Medicare

1 eligible expenses under Part B regardless of hospital confinement,
2 subject to the Medicare Part B deductible.

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

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

9 (2) With respect to skilled nursing facility care, coverage for
10 the actual billed charges up to the coinsurance amount from the
11 21st day to the 100th day, inclusive, in a Medicare benefit period
12 for posthospital skilled nursing facility care eligible under Medicare
13 Part A.

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

17 (4) With respect to 80 percent of the Medicare Part B excess
18 charges, coverage for 80 percent of the difference between the
19 actual Medicare Part B charge as billed, not to exceed any charge
20 limitation established by the Medicare Program or state law, and
21 the Medicare-approved Part B charge.

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

27 (6) With respect to the basic outpatient prescription drug benefit,
28 coverage for 50 percent of outpatient prescription drug charges,
29 after a two-hundred-fifty-dollar (\$250) calendar year deductible,
30 to a maximum of one thousand two hundred fifty dollars (\$1,250)
31 in benefits received by the insured per calendar year, to the extent
32 not covered by Medicare. On and after January 1, 2006, no
33 Medicare supplement contract may be sold or issued if it includes
34 a prescription drug benefit.

35 (7) With respect to the extended outpatient prescription drug
36 benefit, coverage for 50 percent of outpatient prescription drug
37 charges, after a two-hundred-fifty-dollar (\$250) calendar year
38 deductible, to a maximum of three thousand dollars (\$3,000) in
39 benefits received by the insured per calendar year, to the extent
40 not covered by Medicare. On and after January 1, 2006, no

1 Medicare supplement contract may be sold or issued if it includes
2 a prescription drug benefit.

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

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

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

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

25 (i) Fecal occult blood test.

26 (ii) Mammogram.

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

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

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

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

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

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

11 (iii) “Home” shall mean any place used by the insured as a place
12 of residence, provided that the place would qualify as a residence
13 for home health care services covered by Medicare. A hospital or
14 skilled nursing facility shall not be considered the insured’s place
15 of residence.

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

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

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

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

29 (iii) Coverage is limited to the following:

30 (I) No more than the number and type of at-home recovery visits
31 certified as necessary by the covered person’s attending physician.
32 The total number of at-home recovery visits shall not exceed the
33 number of Medicare-approved home health care visits under a
34 Medicare-approved home care plan of treatment.

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

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

39 (IV) Seven visits in any one week.

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

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

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

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

9 (C) Coverage is excluded for the following:

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

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

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

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

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

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

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

35 (5) With respect to skilled nursing facility care, coverage for
36 50 percent of the coinsurance amount for each day used from the
37 21st day to the 100th day, inclusive, in a Medicare benefit period
38 for posthospital skilled nursing facility care eligible under Medicare
39 Part A until the out-of-pocket limitation described in paragraph
40 (10) is met.

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

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

11 (8) Except for coverage provided in paragraph (9), coverage for
12 50 percent of the cost sharing otherwise applicable under Medicare
13 Part B after the enrollee or subscriber pays the Part B deductible,
14 until the out-of-pocket limitation is met as described in paragraph
15 (10).

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

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

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

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

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

33 (3) With respect to skilled nursing facility care, coverage for
34 75 percent of the coinsurance amount for each day used from the
35 21st day to the 100th day, inclusive, in a Medicare benefit period
36 for posthospital skilled nursing facility care eligible under Medicare
37 Part A until the out-of-pocket limitation described in paragraph
38 (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 enrollee or subscriber 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 enrollee or subscriber pays the Part B deductible.

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

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

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

1358.81. The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state with an effective date on or after June 1, 2010. No contract may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement contract for sale with an effective date on or after June 1, 2010. Benefit standards applicable to Medicare

1 supplement contracts issued with an effective date before June 1,
2 2010, remain subject to the requirements of Section 1358.8.

3 (a) The following general standards apply to Medicare
4 supplement contracts and are in addition to all other requirements
5 of this article.

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

13 (2) A Medicare supplement contract shall not indemnify against
14 losses resulting from sickness on a different basis than losses
15 resulting from accidents.

16 (3) A Medicare supplement contract shall provide that benefits
17 designed to cover cost-sharing amounts under Medicare will be
18 changed automatically to coincide with any changes in the
19 applicable Medicare deductible, copayment, or coinsurance
20 amounts. Prepaid or periodic charges may be modified to
21 correspond with those changes.

22 (4) A Medicare supplement contract shall not provide for
23 termination of coverage of a spouse solely because of the
24 occurrence of an event specified for termination of coverage of
25 the enrollee or subscriber, other than the nonpayment of prepaid
26 or periodic charges.

27 (5) Each Medicare supplement contract shall be guaranteed
28 renewable.

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

31 (B) The issuer shall not cancel or nonrenew the contract for any
32 reason other than nonpayment of prepaid or periodic charges or
33 ~~material misrepresentation.~~ *misrepresentation of the risk by the*
34 *applicant that is shown by the plan to be material to the acceptance*
35 *for coverage. The contestability period for Medicare supplement*
36 *contracts shall be two years.*

37 (C) If the Medicare supplement contract is terminated by the
38 master policyholder and is not replaced as provided under
39 subparagraph (E), the issuer shall offer enrollees or subscribers an

1 individual Medicare supplement contract which, at the option of
2 the enrollee or subscriber, does one of the following:

3 (i) Provides for continuation of the benefits contained in the
4 group contract.

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

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

10 (i) Offer the enrollee or subscriber the conversion opportunity
11 described in subparagraph (C).

12 (ii) At the option of the group contractholder, offer the enrollee
13 or subscriber continuation of coverage under the group contract.

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

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

30 (6) Termination of a Medicare supplement contract shall be
31 without prejudice to any continuous loss that commenced while
32 the contract was in force, but the extension of benefits beyond the
33 period during which the contract was in force may be predicated
34 upon the continuous total disability of the enrollee or subscriber,
35 limited to the duration of the contract benefit period, if any, or
36 payment of the maximum benefits. Receipt of Medicare Part D
37 benefits shall not be considered in determining a continuous loss.

38 (7) (A) (i) A Medicare supplement contract shall provide that
39 benefits and prepaid or periodic charges under the contract shall
40 be suspended at the request of the enrollee or subscriber for the

1 period, not to exceed 24 months, in which the enrollee or subscriber
2 has applied for, and is determined to be entitled to, medical
3 assistance under Medi-Cal under Title XIX of the federal Social
4 Security Act, but only if the enrollee or subscriber notifies the
5 issuer of the contract within 90 days after the date the individual
6 becomes entitled to assistance. Upon receipt of timely notice, the
7 insurer shall return directly to the enrollee or subscriber that portion
8 of the prepaid or periodic charge attributable to the period of
9 Medi-Cal eligibility, subject to adjustment for paid claims.

10 (ii) If suspension occurs and if the enrollee or subscriber loses
11 entitlement to medical assistance under Medi-Cal, the Medicare
12 supplement contract shall be automatically ~~reinstated, effective~~
13 *reinstated (effective as of the date of termination of entitlement,*
14 *entitlement)* as of the termination of entitlement if the enrollee or
15 subscriber provides notice of loss of entitlement within 90 days
16 after the date of loss and pays the prepaid or periodic charge
17 attributable to the period, effective as of the date of termination
18 of entitlement or equivalent coverage shall be provided if the prior
19 contract is no longer available.

20 (iii) Each Medicare supplement contract shall provide that
21 benefits and prepaid or periodic charges under the contract shall
22 be suspended (for any period that may be provided by federal
23 regulation) at the request of the enrollee or subscriber if the enrollee
24 or subscriber is entitled to benefits under Section 226(b) of the
25 Social Security Act and is covered under a group health plan (as
26 defined in Section 1862(b)(1)(A)(v) of the Social Security Act).
27 If suspension occurs and if the enrollee or subscriber loses coverage
28 under the group health plan, the contract shall be automatically
29 reinstated (effective as of the date of loss of coverage) if the
30 enrollee or subscriber provides notice of loss of coverage within
31 90 days after the date of the loss and pays the applicable prepaid
32 or periodic charge.

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

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

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

39 (iii) Provide for classification of prepaid or periodic charges on
40 terms at least as favorable to the enrollee or subscriber as the

1 classification of the prepaid or periodic charge that would have
2 applied to the enrollee or subscriber had the coverage not been
3 suspended.

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

6 (9) 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 (10) A Medicare supplement contract shall additionally meet
12 any other minimum benefit standards as established by the director.

13 (11) 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
25 clear and simple terms so as to facilitate comprehension. The
26 notice shall not contain or be accompanied by any solicitation.

27 (12) 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, B, C, D, F, F with high deductible, G, M, and N,
34 every issuer of Medicare supplement benefit plans shall make
35 available a contract including only the following basic “core”
36 package of benefits to each prospective enrollee or subscriber. An
37 issuer may make available to prospective enrollees or subscribers
38 any of the other Medicare supplement benefit plans in addition to
39 the basic core package, but not in lieu of 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 through the 90th day, inclusive, in any Medicare benefit
4 period.

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

8 (3) Upon exhaustion of the Medicare hospital inpatient coverage,
9 including the lifetime reserve days, coverage of 100 percent of the
10 Medicare Part A eligible expenses for hospitalization paid at the
11 applicable prospective payment system (PPS) 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 as payment in full and may not bill
15 the insured for any balance.

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

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

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

27 (c) The following additional benefits shall be included in
28 Medicare supplement benefit plans B, C, D, F, F with high
29 deductible, G, M, and N, *consistent with the plan type and benefits*
30 *for each plan* as provided in Section 1358.91:

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

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

37 (3) With respect to skilled nursing facility care, coverage for
38 the actual billed charges up to the coinsurance amount from the
39 21st day through the 100th day in a Medicare benefit period for

1 posthospital skilled nursing facility care eligible under Medicare
2 Part A.

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

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 charges 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.

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

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

25 1358.9. The following standards are applicable to all Medicare
26 supplement contracts delivered or issued for delivery in this state
27 on or after July 21, 1992, and with an effective date prior to June
28 1, 2010.

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

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

36 (c) Benefit plans shall be uniform in structure, language,
37 designation and format to the standard benefit plans A to J,
38 inclusive, listed in subdivision (e), and shall conform to the
39 definitions in Section 1358.4. Each benefit shall be structured in
40 accordance with the format provided in subdivisions (b), (c), (d),

1 and (e) of Section 1358.8 and list the benefits in the order listed
2 in subdivision (e). For purposes of this section, “structure,
3 language, and format” means style, arrangement, and overall
4 content of a benefit.

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

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

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

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

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

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

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

35 (6) Standardized Medicare supplement benefit plan F shall
36 include only the following: the core benefit, plus the Medicare
37 Part A deductible, the skilled nursing facility care, the Medicare
38 Part B deductible, 100 percent of the Medicare Part B excess
39 charges, and medically necessary emergency care in a foreign

country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 1358.8, respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on the calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

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

1 (13) Standardized Medicare supplement benefit plan K shall
2 consist of only those benefits described in subdivision (d) of
3 Section 1358.8.

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

7 (f) An issuer may, with the prior approval of the director, offer
8 contracts with new or innovative benefits in addition to the benefits
9 provided in a contract that otherwise complies with the applicable
10 standards. The new or innovative benefits may include benefits
11 that are appropriate to Medicare supplement contracts, that are not
12 otherwise available and that are cost-effective and offered in a
13 manner that is consistent with the goal of simplification of
14 Medicare supplement contracts. On and after January 1, 2006, the
15 innovative benefit shall not include an outpatient prescription drug
16 benefit.

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

19 1358.91. The following standards are applicable to all Medicare
20 supplement contracts delivered or issued for delivery in this state
21 with an effective date on or after June 1, 2010. No contract may
22 be advertised, solicited, delivered, or issued for delivery in this
23 state as a Medicare supplement contract unless it complies with
24 these benefit plan standards. Benefit plan standards applicable to
25 Medicare supplement contracts issued with an effective date before
26 June 1, 2010, remain subject to the requirements of Section 1358.9.

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

30 (2) If an issuer makes available any of the additional benefits
31 described in subdivision (c) of Section 1358.81, or offers
32 standardized benefit plan K or L, as described in paragraphs (8)
33 and (9) of subdivision (e), then the issuer shall make available to
34 each prospective enrollee and subscriber, in addition to a contract
35 with only the basic (core) benefits as described in paragraph (1),
36 a contract containing either standardized benefit plan C, as
37 described in paragraph (3) of subdivision (e), or standardized
38 benefit plan F, as described in paragraph (5) of subdivision (e).

39 (b) No groups, packages or combinations of Medicare
40 supplement benefits other than those listed in this section shall be

1 offered for sale in this state, except as may be permitted in
2 subdivision (f) and by Section 1358.10.

3 (c) Benefit plans shall be uniform in structure, language,
4 designation, and format to the standard benefit plans listed in
5 subdivision (e) and conform to the definitions in Section 1358.4.
6 Each benefit shall be structured in accordance with the format
7 provided in subdivisions (b) and (c) of Section 1358.81; or, in the
8 case of plan K or L, in paragraphs (8) or (9) of subdivision (e) of
9 Section 1358.91 and list the benefits in the order shown in
10 subdivision (e). For purposes of this section, “structure, language,
11 and format” means style, arrangement, and overall content of a
12 benefit.

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

16 (e) With respect to the makeup of 2010 standardized benefit
17 plans, the following shall apply:

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

21 (2) Standardized Medicare supplement benefit plan B 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 as defined in paragraph (1) of
25 subdivision (c) of Section 1358.81.

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

33 (4) Standardized Medicare supplement benefit plan D shall
34 include only the following: the basic (core) benefit, as defined in
35 subdivision (b) of Section 1358.81, plus 100 percent of the
36 Medicare Part A deductible, skilled nursing facility care, and
37 medically necessary emergency care in ~~an~~ a foreign country, as
38 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
39 1358.81, respectively.

(5) Standardized Medicare supplement plan F 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 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.

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

(A) The 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) Standardized Medicare supplement plan N 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, and medically necessary emergency care in a foreign country, as defined in paragraphs (1), (3), and (6) of subdivision (c) of Section 1358.81, 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 enrollee or subscriber 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 director, offer contracts with new or innovative benefits, in addition to the

1 standardized benefits provided in a contract that otherwise complies
2 with the applicable standards. The new or innovative benefits shall
3 include only benefits that are appropriate to Medicare supplement
4 contracts, are new or innovative, are not otherwise available, and
5 are cost effective. Approval of new or innovative benefits shall
6 not adversely impact the goal of Medicare supplement
7 simplification. New or innovative benefits shall not include an
8 outpatient prescription drug benefit. New or innovative benefits
9 shall not be used to change or reduce benefits, including a change
10 of any cost-sharing provision, in any standardized plan.

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

13 1358.11. (a) (1) An issuer shall not deny or condition the
14 offering or effectiveness of any Medicare supplement contract
15 available for sale in this state, nor discriminate in the pricing of a
16 contract because of the health status, claims experience, receipt of
17 health care, or medical condition of an applicant in the case of an
18 application for a contract that is submitted prior to or during the
19 six-month period beginning with the first day of the first month
20 in which an individual is both 65 years of age or older and is
21 enrolled for benefits under Medicare Part B. Each Medicare
22 supplement contract currently available from an issuer shall be
23 made available to all applicants who qualify under this subdivision
24 and who are 65 years of age or older.

25 (2) An issuer shall make available Medicare supplement benefit
26 plans A, B, C, and F, if currently available, to an applicant who
27 qualifies under this subdivision who is 64 years of age or younger
28 and who does not have end-stage renal disease. An issuer shall
29 also make available to those applicants, Medicare supplement
30 benefit plan H, I, or J, if currently available, and commencing
31 January 1, 2007, shall make available to them Medicare supplement
32 benefit plan K or L, if currently available. The selection among
33 Medicare supplement benefit plan H, I, or J and the selection
34 between Medicare supplement benefit plan K or L shall be made
35 at the issuer's discretion.

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

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

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

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

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

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

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

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

38 (C) Termination of health care services for a military retiree or
39 the retiree's Medicare eligible spouse or dependent as a result of
40 a military base closure or loss of access to health care services

1 because the base no longer offers services or because the individual
2 relocates.

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

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

16 (g) (1) An individual whose coverage was terminated by a
17 Medicare Advantage plan shall be entitled to an additional 60-day
18 open enrollment period to be added on to and run consecutively
19 after any open enrollment period authorized by federal law or
20 regulation, for any and all Medicare supplement coverage available
21 on a guaranteed basis under state and federal law or regulations
22 for persons terminated by their Medicare Advantage plan.

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

29 (h) (1) An individual shall be entitled to an annual open
30 enrollment period lasting 30 days or more, commencing with the
31 individual’s birthday, during which time that person may purchase
32 any Medicare supplement coverage that offers benefits equal to
33 or lesser than those provided by the previous coverage. During
34 this open enrollment period, no issuer that falls under this provision
35 shall deny or condition the issuance or effectiveness of Medicare
36 supplement coverage, nor discriminate in the pricing of coverage,
37 because of health status, claims experience, receipt of health care,
38 or medical condition of the individual if, at the time of the open
39 enrollment period, the individual is covered under another
40 Medicare supplement policy, certificate, or contract. An issuer that

1 offers Medicare supplement contracts shall notify an enrollee of
2 his or her rights under this subdivision at least 30 and no more
3 than 60 days before the beginning of the open enrollment period.

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

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

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

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

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

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

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

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

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

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

33 (J) (i) *A 1990 standardized Medicare supplement benefit plan*
34 *J shall be deemed to offer benefits equal to those provided by a*
35 *2010 standardized Medicare supplement benefit plan F.*

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

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

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

7 (M) Except as provided in clause (ii) of subparagraph (J), an
8 individual with a 1990 Medicare supplement policy with a high
9 deductible rider may choose only a 2010 standardized Medicare
10 supplement benefit Plan A.

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

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

18 1358.12. (a) (1) With respect to the guaranteed issue of a
19 Medicare supplement contract, eligible persons are those
20 individuals described in subdivision (b) who seek to enroll under
21 the contract during the period specified in subdivision (c), and who
22 submit evidence of the date of termination or disenrollment or
23 enrollment in Medicare Part D with the application for a Medicare
24 supplement contract.

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

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

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

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

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

37 (1) The individual is enrolled under an employee welfare benefit
38 plan that provides health benefits that supplement the benefits
39 under Medicare, the plan either terminates or ceases to provide all
40 of those supplemental health benefits to the individual, and the

1 employer no longer provides the individual with insurance that
2 covers all of the payment for the 20-percent coinsurance.

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

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

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

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

19 (D) The Medicare Advantage plan in which the individual is
20 enrolled reduces any of its benefits or increases the amount of cost
21 sharing or discontinues for other than good cause relating to quality
22 of care, its relationship or contract under the plan with a provider
23 who is currently furnishing services to the individual. An individual
24 shall be eligible under this subparagraph for a Medicare supplement
25 contract issued by the same issuer through which the individual
26 was enrolled at the time the reduction, increase, or discontinuance
27 described above occurs or, commencing January 1, 2007, for one
28 issued by a subsidiary of the parent company of that issuer or by
29 a network that contracts with the parent company of that issuer.

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

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

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

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

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

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

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

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

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

15 (iii) An organization under an agreement under Section
16 1833(a)(1)(A) of the Social Security Act (health care prepayment
17 plan).

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

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

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

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

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

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

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

34 (A) The individual was enrolled under a Medicare supplement
35 contract and terminates enrollment and subsequently enrolls, for
36 the first time, with any Medicare Advantage organization under a
37 Medicare Advantage plan under Medicare Part C, any eligible
38 organization under a contract under Section 1876 of the Social
39 Security Act (Medicare cost), any similar organization operating
40 under demonstration project authority, any PACE provider under

1 Section 1894 of the Social Security Act, or a Medicare Select
2 policy.

3 (B) The subsequent enrollment under subparagraph (A) is
4 terminated by the individual during any period within the first 12
5 months of the subsequent enrollment (during which the enrollee
6 is permitted to terminate the subsequent enrollment under Section
7 1851(e) of the federal Social Security Act).

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

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

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

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

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

30 (2) In the case of an individual described in paragraphs (2), (3),
31 (4), (6), and (7) of subdivision (b) whose enrollment is terminated
32 involuntarily, the guaranteed issue period begins on the date that
33 the individual receives a notice of termination and ends 63 days
34 after the date the applicable coverage is terminated.

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

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

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

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

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

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

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

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

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

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

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement contract in which he or she was most recently enrolled, if available from the same issuer. If that contract is not available, the eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, 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 contract with an outpatient prescription drug benefit, is entitled to a Medicare supplement contract that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, or L that is offered by any issuer.

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

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

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the

organization that terminates the contract or agreement, the issuer terminating the policy or contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

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

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

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

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

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

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

(3) Paying the participating physician or supplier directly.

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

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

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

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

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

12 1358.17. (a) (1) Medicare supplement contracts shall include
13 a renewal or continuation provision. The language or specifications
14 of the provision shall be consistent with subdivision (a) of Section
15 1365 and the rules adopted thereunder. The provision shall be
16 appropriately captioned and shall appear on the first page of the
17 contract, and shall include any reservation by the issuer of the right
18 to change prepaid or periodic charges and any automatic renewal
19 increases based on the enrollee's age.

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

23 (b) (1) Except for contract amendments by which the issuer
24 effectuates a request made in writing by the enrollee, exercises a
25 specifically reserved right under a Medicare supplement contract,
26 or is required to reduce or eliminate benefits to avoid duplication
27 of Medicare benefits, all amendments to a Medicare supplement
28 contract after the date of issue or upon reinstatement or renewal
29 that reduce or eliminate benefits or coverage in the contract shall
30 require a signed acceptance by the subscriber. After the date of
31 contract issue, any amendment that increases benefits or coverage
32 with a concomitant increase in prepaid or periodic charges during
33 the contract term shall be agreed to in writing signed by the
34 subscriber, unless the benefits are required by the minimum
35 standards for Medicare supplement contracts, or if the increased
36 benefits or coverage is required by law. If a separate additional
37 charge is made for benefits provided in connection with contract
38 amendments, the charge shall be set forth in the contract.

39 (2) An issuer shall not in any way reduce or eliminate any
40 benefit or coverage under a Medicare supplement contract at any

1 time after the date of entering the contract, including dates of
2 reinstatement or renewal, unless and until the change is voluntarily
3 agreed to in writing signed by the subscriber or enrollee, or is
4 required to reduce or eliminate benefits to avoid duplication of
5 Medicare benefits. The issuer shall not increase benefits or
6 coverage with a concomitant increase in prepaid or periodic charges
7 during the term of the contract unless and until the change is
8 voluntarily agreed to in writing signed by the subscriber or enrollee
9 or unless the increased benefits or coverage is required by law or
10 regulation.

11 (c) Medicare supplement contracts shall not provide for the
12 payment of benefits based on standards described as “usual and
13 customary,” “reasonable and customary,” or words of similar
14 import.

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

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

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

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

36 (f) (1) Issuers of health care service plan contracts that provide
37 hospital or medical expense coverage on an expense incurred or
38 indemnity basis to persons eligible for Medicare shall provide to
39 those applicants a guide to health insurance for people with
40 Medicare in the form developed jointly by the National Association

1 of Insurance Commissioners and the Centers for Medicare and
2 Medicaid Services and in a type size no smaller than 12-point type.
3 Delivery of the guide shall be made whether or not the contracts
4 are advertised, solicited, or issued for delivery as Medicare
5 supplement contracts as defined in this article. Except in the case
6 of direct response issuers, delivery of the guide shall be made to
7 the applicant at the time of application, and acknowledgment of
8 receipt of the guide shall be obtained by the issuer. Direct response
9 issuers shall deliver the guide to the applicant upon request, but
10 not later than at the time the contract is delivered.

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

14 (g) As soon as practicable, but no later than 30 days prior to the
15 annual effective date of any Medicare benefit changes, an issuer
16 shall notify its enrollees and subscribers of modifications it has
17 made to Medicare supplement contracts in a format acceptable to
18 the director. The notice shall include both of the following:

19 (1) A description of revisions to the Medicare Program and a
20 description of each modification made to the coverage provided
21 under the Medicare supplement contract.

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

24 (h) The notice of benefit modifications and any adjustments of
25 prepaid or periodic charges shall be in outline form and in clear
26 and simple terms so as to facilitate comprehension.

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

29 (j) (1) Issuers shall provide an outline of coverage to all
30 applicants at the time application is presented to the prospective
31 applicant and, except for direct response policies, shall obtain an
32 acknowledgment of receipt of the outline from the applicant. If an
33 outline of coverage is provided at the time of application and the
34 Medicare supplement contract is issued on a basis which would
35 require revision of the outline, a substitute outline of coverage
36 properly describing the contract shall accompany the contract when
37 it is delivered and contain the following statement, in no less than
38 12-point type, immediately above the company name:

39

1 “NOTICE: Read this outline of coverage carefully. It is not
2 identical to the outline of coverage provided upon application and
3 the coverage originally applied for has not been issued.”
4

5 (2) The outline of coverage provided to applicants pursuant to
6 this section consists of four parts: a cover page, information about
7 prepaid or periodic charges, disclosure pages, and charts displaying
8 the features of each benefit plan offered by the issuer. The outline
9 of coverage shall be in the language and format prescribed below
10 in no less than 12-point type. All Medicare supplement plans
11 authorized by federal law shall be shown on the cover page, and
12 the plans that are offered by the issuer shall be prominently
13 identified. Information about prepaid or periodic charges for plans
14 that are offered shall be shown on the cover page or immediately
15 following the cover page and shall be prominently displayed. The
16 charge and mode shall be stated for all plans that are offered to
17 the prospective applicant. All possible charges for the prospective
18 applicant shall be illustrated.

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

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

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

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

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

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

1 The text shall read: “Medicare supplement contracts can be sold
2 in only standard plans. This chart shows the benefits included in
3 each plan. Every insurance company must offer Plan A. Some
4 plans may not be available. Plans E, H, I, and J are no longer
5 available for sale. [This sentence shall not appear after June 1,
6 2011.]”

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

9
10 INFORMATION ABOUT PREPAID OR PERIODIC
11 CHARGES
12

13 [Insert plan’s name] can only raise your charges if it raises the
14 charge for all contracts like yours in this state. [If the charge is
15 based on the increasing age of the enrollee, include information
16 specifying when charges will change.]

17
18 DISCLOSURES
19

20 Use this outline to compare benefits and charges among policies.
21 [The following additional language shall be included under
22 “DISCLOSURES” for contracts with effective dates on or after
23 June 1, 2010, but shall not appear after June 1, 2011.]

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

28
29 READ YOUR POLICY VERY CAREFULLY
30

31 This is only an outline describing the most important features
32 of your Medicare supplement plan contract. This is not the plan
33 contract and only the actual contract provisions will control. You
34 must read the contract itself to understand all of the rights and
35 duties of both you and [insert the health care service plan’s name].

36
37 RIGHT TO RETURN POLICY
38

39 If you find that you are not satisfied with your contract, you may
40 return it to [insert plan’s address]. If you send the contract back

1 to us within 30 days after you receive it, we will treat the contract
2 as if it had never been issued and return all of your payments.

3
4 POLICY REPLACEMENT

5
6 If you are replacing other health coverage, do NOT cancel it
7 until you have actually received your new contract and are sure
8 you want to keep it.

9
10 NOTICE

11
12 This contract may not fully cover all of your medical costs.
13 Neither [insert the health care service plan's name] nor its agents
14 are connected with Medicare.

15 This outline of coverage does not give all the details of Medicare
16 coverage. Contact your local social security office or consult "The
17 Medicare Handbook" for further details and limitations applicable
18 to Medicare.

19
20 COMPLETE ANSWERS ARE VERY IMPORTANT

21
22 When you fill out the application for the new contract, be sure
23 to answer truthfully and completely all questions about your
24 medical and health history. The company may cancel your contract
25 and refuse to pay any claims if you leave out or falsify important
26 medical information. [If the contract is guaranteed issue, this
27 paragraph need not appear.] Review the application carefully before
28 you sign it. Be certain that all information has been properly
29 recorded. [The charts displaying the features of each benefit plan
30 offered by the issuer shall use the uniform format and language
31 shown in the charts set forth in Section 17 of the Model Regulation
32 to Implement the NAIC Medicare Supplement Insurance Minimum
33 Standards Model Act, as most recently adopted by the National
34 Association of Insurance Commissioners. No more than four
35 benefit plans may be shown on one chart. For purposes of
36 illustration, charts for each benefit plan are set forth below. An
37 issuer may use additional benefit plan designations on these charts.]

38 [Include an explanation of any innovative benefits on the cover
39 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 applicants pursuant to this section, including the format of tables, charts, and other information.

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

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

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

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

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

4 SEC. 12. Section 1358.18 of the Health and Safety Code is
5 amended to read:

6 1358.18. In the interest of full and fair disclosure, and to assure
7 the availability of necessary consumer information to potential
8 subscribers or enrollees not possessing a special knowledge of
9 Medicare, health care service plans, or Medicare supplement
10 contracts, an issuer shall comply with the following provisions:

11 (a) Application forms shall include the following questions
12 designed to elicit information as to whether, as of the date of the
13 application, the applicant currently has Medicare supplement,
14 Medicare Advantage, Medi-Cal coverage, or another health
15 insurance policy or certificate or plan contract in force or whether
16 a Medicare supplement contract is intended to replace any other
17 disability policy or certificate, or plan contract, presently in force.
18 A supplementary application or other form to be signed by the
19 applicant and solicitor containing those questions and statements
20 may be used.

21
22 “(Statements)
23

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

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

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

30 (4) If after purchasing this contract you become eligible for
31 Medi-Cal, the benefits and premiums under your Medicare
32 supplement contract can be suspended, if requested, during your
33 entitlement to benefits under Medi-Cal or Medicaid for 24 months.
34 You must request this suspension within 90 days of becoming
35 eligible for Medi-Cal or Medicaid. If you are no longer entitled to
36 Medi-Cal or Medicaid, your suspended Medicare supplement
37 contract or if that is no longer available, a substantially equivalent
38 contract, will be reinstituted if requested within 90 days of losing
39 Medi-Cal or Medicaid eligibility. If the Medicare supplement
40 contract provided coverage for outpatient prescription drugs and

1 you enrolled in Medicare Part D while your contract was
2 suspended, the reinstituted contract will not have outpatient
3 prescription drug coverage, but will otherwise be substantially
4 equivalent to your coverage before the date of the suspension.

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

22 (6) Counseling services are available in this state to provide
23 advice concerning your purchase of Medicare supplement coverage
24 and concerning medical assistance through the Medi-Cal or
25 Medicaid Program, including benefits as a qualified Medicare
26 beneficiary (QMB) and a specified low-income Medicare
27 beneficiary (SLMB). Information regarding counseling services
28 may be obtained from the California Department of Aging.

29
30 (Questions)

31
32 If you lost or are losing other health insurance coverage and
33 received a notice from your prior insurer saying you were eligible
34 for guaranteed issue of a Medicare supplement insurance contract
35 or that you had certain rights to buy such a contract, you may be
36 guaranteed acceptance in one or more of our Medicare supplement
37 plans. Please include a copy of the notice from your prior insurer
38 with your application. PLEASE ANSWER ALL QUESTIONS.

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

40 To the best of your knowledge,

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

2 Yes_____ No_____

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

4 Yes_____ No_____

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

6 (2) Are you covered for medical assistance through California's
7 Medi-Cal program

8 NOTE TO APPLICANT: If you have a share of cost under the
9 Medi-Cal program, please answer NO to this question.

10 Yes_____ No_____

11 If yes,

12 (a) Will Medi-Cal pay your premiums for this Medicare
13 supplement contract

14 Yes_____ No_____

15 (b) Do you receive benefits from Medi-Cal OTHER THAN
16 payments toward your Medicare Part B premium

17 Yes_____ No_____

18 (3) (a) If you had coverage from any Medicare plan other than
19 original Medicare within the past 63 days (for example, a Medicare
20 Advantage plan or a Medicare HMO or PPO), fill in your start and
21 end dates below. If you are still covered under this plan, leave
22 "END" blank.

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

24 (b) If you are still covered under the Medicare plan, do you
25 intend to replace your current coverage with this new Medicare
26 supplement contract

27 Yes_____ No_____

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

29 Yes_____ No_____

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

32 Yes_____ No_____

33 (4) (a) Do you have another Medicare supplement policy or
34 certificate or contract in force

35 Yes_____ No_____

36 (b) If so, with what company, and what plan do you have
37 [optional for Direct Mailers]

38 Yes_____ No_____

39 (c) If so, do you intend to replace your current Medicare
40 supplement policy or certificate or contract with this contract

1 Yes____ No____

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

5 Yes____ No____

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

7 _____

8 _____

9 _____

10 _____

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

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

13 (If you are still covered under the other policy, leave “END”
14 blank).

15
16 (b) Solicitors shall list any other health insurance policies or
17 plan contracts they have sold to the applicant as follows:

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

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

21 (c) An issuer issuing Medicare supplement contracts without a
22 solicitor or solicitor firm (a direct response issuer) shall return to
23 the applicant, upon delivery of the contract, a copy of the
24 application or supplemental forms, signed by the applicant and
25 acknowledged by the issuer.

26 (d) Upon determining that a sale will involve replacement of
27 Medicare supplement coverage, any issuer, other than a direct
28 response issuer, or its agent, shall furnish the applicant, prior to
29 issuance for delivery of the Medicare supplement contract, a notice
30 regarding replacement of Medicare supplement coverage. One
31 copy of the notice signed by the applicant and the agent, except
32 where the coverage is sold without an agent, shall be provided to
33 the applicant and an additional signed copy shall be retained by
34 the issuer. A direct response issuer shall deliver to the applicant
35 at the time of the issuance of the contract the notice regarding
36 replacement of Medicare supplement coverage.

37 (e) The notice required by subdivision (d) for an issuer shall be
38 provided in substantially the following form in no less than
39 12-point type:

1 NOTICE TO APPLICANT REGARDING REPLACEMENT
2 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
3 ADVANTAGE
4
5

6 (Company name and address)
7
8

9 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN
10 THE FUTURE

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

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

37 (2) If the issuer of the Medicare supplement contract being
38 applied for does not impose, or is otherwise prohibited from
39 imposing, preexisting condition limitations, please skip to statement
40 3 below. Health conditions that you may presently have

(preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan 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 contract.

(4) If you still wish to terminate your present policy or contract 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 plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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.

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

(Signature of Solicitor, Solicitor Firm, or Other Representative)
[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

(Applicant's Signature)

(Date)

(f) The application form or other consumer information for persons eligible for Medicare and used by an issuer shall contain as an attachment a Medicare supplement buyer's guide in the form approved by the director. The application or other consumer information, containing as an attachment the buyer's guide, shall be mailed or delivered to each applicant applying for that coverage at or before the time of application and, to establish compliance

with this subdivision, the issuer shall obtain an acknowledgment of receipt of the attached buyer's guide from each applicant. No issuer shall make use of or otherwise disseminate any buyer's guide that does not accurately outline current Medicare supplement benefits. No issuer shall be required to provide more than one copy of the buyer's guide to any applicant.

(g) An issuer may comply with the requirement of this section in the case of group contracts by causing the subscriber (1) to disseminate copies of the disclosure form containing as an attachment the buyer's guide to all persons eligible under the group contract at the time those persons are offered the Medicare supplement plan, and (2) collecting and forwarding to the issuer an acknowledgment of receipt of the disclosure form containing as an attachment the buyer's guide from each enrollee.

(h) For an individual who is subject to an open enrollment period or who is guaranteed issuance of any Medicare supplement coverage as described in Section 1358.11 or 1358.12, an issuer ~~shall not require or use, for the purpose of determining eligibility or premium levels, or for any other purpose not explicitly disclosed to the applicant pursuant to this subdivision, the applicant's health information, including health information acquired in compliance with the federal Health Insurance Portability and Accountability Act of 1996, or require an applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. A statement of this prohibition shall be included on the application in clear and conspicuous language, in addition to the open enrollment and guaranteed issue periods described in Sections 1358.11 and 1358.12. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage. This subdivision shall not preclude an issuer from requesting an applicant to voluntarily provide health information, provided that the issuer obtains authorization in compliance with the applicable requirements under the federal Health Insurance Portability and Accountability Act of 1996. shall not require or request health information from an applicant or require or request the applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information or to sign a form required by the federal Health~~

1 *Insurance Portability and Accountability Act of 1996 during a*
2 *period of open enrollment or guaranteed issuance, as described*
3 *in Section 1358.11 or 1358.12, of any Medicare supplement*
4 *coverage and shall inform the applicant of the periods of open*
5 *enrollment or guaranteed issuance of Medicare supplement*
6 *coverage. A supplementary application or other form containing*
7 *those statements that the applicant and solicitor are required to*
8 *sign may be used for this purpose. This subdivision shall not*
9 *prohibit an issuer from requiring proof of eligibility for a*
10 *guaranteed issuance of Medicare supplement coverage.*

11 SEC. 13. Section 1358.20 of the Health and Safety Code is
12 amended to read:

13 1358.20. (a) An issuer, directly or through solicitors or other
14 representatives, shall do each of the following:

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

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

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

23
24 “Notice to buyer: This Medicare supplement contract may not
25 cover all of your medical expenses.”
26

27 (4) Inquire and otherwise make every reasonable effort to
28 identify whether a prospective applicant for a Medicare supplement
29 contract already has health care coverage and the types and
30 amounts of that coverage.

31 (5) Provide, on the application form for Medicare supplement
32 contracts, a statement that reads as follows: “A rate guide is
33 available that compares the policies sold by different insurers. You
34 can obtain a copy of this rate guide by calling the Department of
35 Insurance’s *Managed Health Care*’s consumer toll-free telephone
36 number ~~(1-800-927-HELP)~~ (1-888-HMO-2219), by calling the
37 Health Insurance Counseling and Advocacy Program (HICAP)
38 toll-free telephone number (1-800-434-0222), or by accessing the
39 Department of Insurance’s *Managed Health Care*’s Internet Web
40 site ~~(www.insurance.ca.gov)~~ (www.dmhc.ca.gov).”

1 (6) Establish auditable procedures for verifying compliance
2 with this subdivision.

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

5 (1) Twisting, which means knowingly making any misleading
6 representation or incomplete or fraudulent comparison of any
7 coverages or issuers for the purpose of inducing or tending to
8 induce, any person to lapse, forfeit, surrender, terminate, retain,
9 pledge, assign, borrow on, or convert any coverage or to take out
10 coverage with another plan or insurer.

11 (2) High pressure tactics, which means employing any method
12 of marketing having the effect of or tending to induce the purchase
13 of coverage through force, fright, threat, whether explicit or
14 implied, or undue pressure to purchase or recommend the purchase
15 of coverage.

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

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

24 SEC. 14. Section 1358.24 is added to the Health and Safety
25 Code, to read:

26 1358.24. This section applies to all contracts that become
27 effective on or after May 21, 2009.

28 (a) In addition to the requirements set forth under Sections
29 1365.5 and 1374.7, an issuer of a Medicare supplement contract
30 shall adhere to the requirements imposed by the federal Genetic
31 Information Nondiscrimination Act of 2008 (Public Law 110-233),
32 as follows:

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

38 (2) The issuer shall not discriminate in the pricing of the
39 contract, including the adjustment of prepaid or periodic charges,

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

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

6 (1) Deny or condition the issuance or effectiveness of the
7 contract or increase the prepaid or periodic charge for a group
8 based on the manifestation of a disease or disorder of an enrollee,
9 subscriber, or applicant.

10 (2) Increase the prepaid or periodic charge for any contract
11 issued to an individual based on the manifestation of a disease or
12 disorder of an individual who is covered under the contract. For
13 purposes of this paragraph, the manifestation of a disease or
14 disorder in one individual shall not also be used as genetic
15 information about other group members and to further increase
16 the prepaid or periodic charge for the group.

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

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

27 (e) For purposes of carrying out subdivision (d), an issuer of a
28 Medicare supplement contract may request only the minimum
29 amount of information necessary to accomplish the intended
30 purpose.

31 ~~(f) Notwithstanding subdivision (b) of Section 1374.7 or~~
32 ~~subdivision (c), an issuer of a Medicare supplement contract may~~
33 ~~request, but not require, that an individual or a family member of~~
34 ~~that individual undergo a genetic test if each of the following~~
35 ~~conditions is met:~~

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

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

4 ~~(A) Compliance with the request is voluntary.~~

5 ~~(B) Noncompliance will have no effect on enrollment status,~~
6 ~~prepaid or periodic charges, or contribution amounts.~~

7 ~~(3) No genetic information collected or acquired under this~~
8 ~~subdivision shall be used for any prohibited purpose described in~~
9 ~~Section 1365.5 or subdivision (a) of Section 1374.7, as well as any~~
10 ~~of the following: underwriting, determination of eligibility to enroll~~
11 ~~or maintain enrollment status, determination of prepaid or periodic~~
12 ~~charges, or the issuance, renewal, or replacement of a contract.~~

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

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

20 ~~(g)~~

21 ~~(f) An issuer of a Medicare supplement contract shall not~~
22 ~~request, require, seek, or purchase genetic information for~~
23 ~~underwriting purposes.~~

24 ~~(h)~~

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

30 ~~(i)~~

31 ~~(h) If an issuer of a Medicare supplement contract obtains~~
32 ~~genetic information incidental to the requesting, requiring, or~~
33 ~~purchasing of other information concerning any individual or a~~
34 ~~family member of that individual, the request, requirement, or~~
35 ~~purchase shall not be considered a violation of subdivision-(h) (g)~~
36 ~~if the request, requirement, or purchase is not in violation of~~
37 ~~subdivision-(g) (f). However, the issuer shall not use any genetic~~
38 ~~information obtained under this section for any prohibited purpose~~
39 ~~described in this section or in Sections 1365.5 and 1374.7.~~

40 ~~(j)~~

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

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

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

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

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

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

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

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

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

1 (C) The application of any preexisting condition exclusion under
2 the contract.

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

5 SEC. 15. Section 785 of the Insurance Code is amended to
6 read:

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

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

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

18 (1) Medicare supplement insurance as defined in subdivision
19 (m) of Section 10192.4.

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

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

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

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

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

29 (7) Accidental death insurance.

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

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

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

38 SEC. 16. Section 10192.4 of the Insurance Code is amended
39 to read:

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

(a) “Applicant” means:

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

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

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

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

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

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

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

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

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

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

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

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

(F) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

21 (D) Workers' compensation or similar insurance.

22 (E) Automobile medical payment insurance.

23 (F) Credit-only insurance.

24 (G) Coverage for onsite medical clinics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) “Medicare supplement policy” means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395mm) or an issued policy under a

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

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

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

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

~~(q)~~
(p) “2010 standardized Medicare supplement benefit plan,” “2010 standardized benefit plan,” or “2010 plan” means a group or individual policy of Medicare supplement insurance issued with an effective date on or after June 1, 2010.

~~(r)~~
(q) “Secretary” means the Secretary of the United States Department of Health and Human Services.

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

10192.6. (a) Except for permitted preexisting condition clauses as described in Sections 10192.7, 10192.8, and 10192.81, a policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy if the policy or certificate contains

1 limitations or exclusions on coverage that are more restrictive than
2 those of Medicare.

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

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

9 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of
10 Section 10192.8, a Medicare supplement policy with benefits for
11 outpatient prescription drugs that was issued prior to January 1,
12 2006, shall be renewed for current policyholders, at the option of
13 the policyholder, who do not enroll in Medicare Part D.

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

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

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

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

27 SEC. 18. Section 10192.8 of the Insurance Code is amended
28 to read:

29 10192.8. The following standards are applicable to all Medicare
30 supplement policies or certificates advertised, solicited, or issued
31 for delivery on or after January 1, 2001, and with an effective date
32 prior to June 1, 2010. A policy or certificate shall not be advertised,
33 solicited, or issued for delivery as a Medicare supplement policy
34 or certificate unless it complies with these benefit standards.

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

38 (1) A Medicare supplement policy or certificate shall not exclude
39 or limit benefits for losses incurred more than six months from the
40 effective date of coverage because it involved a preexisting

1 condition. The policy or certificate shall not define a preexisting
2 condition more restrictively than a condition for which medical
3 advice was given or treatment was recommended by or received
4 from a physician within six months before the effective date of
5 coverage.

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

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

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

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

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

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

28 (C) If the Medicare supplement policy is terminated by the
29 master policyholder and is not replaced as provided under
30 subparagraph (E), the issuer shall offer certificate holders an
31 individual Medicare supplement policy that, at the option of the
32 certificate holder, either provides for continuation of the benefits
33 contained in the group policy or provides for benefits that otherwise
34 meet the requirements of one of the standardized policies defined
35 in this article.

36 (D) If an individual is a certificate holder in a group Medicare
37 supplement policy and membership in the group is terminated, the
38 issuer shall either offer the certificate holder the conversion
39 opportunity described in subparagraph (C) or, at the option of the

1 group policyholder, shall offer the certificate holder continuation
2 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 (F) If a Medicare supplement policy eliminates an outpatient
20 prescription drug benefit as a result of requirements imposed by
21 the Medicare Prescription Drug, Improvement, and Modernization
22 Act of 2003 (P.L. 108-173), the policy as modified as a result of
23 that act shall be deemed to satisfy the guaranteed renewal
24 requirements of this paragraph.

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

33 (7) (A) (i) A Medicare supplement policy or certificate shall
34 provide that benefits and premiums under the policy or certificate
35 shall be suspended at the request of the policyholder or certificate
36 holder for the period, not to exceed 24 months, in which the
37 policyholder or certificate holder has applied for and is determined
38 to be entitled to Medi-Cal, but only if the policyholder or certificate
39 holder notifies the issuer of the policy or certificate within 90 days
40 after the date the individual becomes entitled to assistance. Upon

1 receipt of timely notice, the insurer shall return directly to the
 2 insured that portion of the premium attributable to the period of
 3 Medi-Cal eligibility, subject to adjustment for paid claims. If
 4 suspension occurs and if the policyholder or certificate holder loses
 5 entitlement to Medi-Cal, the policy or certificate shall be
 6 automatically ~~reinstated, effective~~ *reinstated (effective* as of the
 7 date of termination of ~~entitlement~~ *entitlement)* as of the termination
 8 of entitlement if the policyholder or certificate holder provides
 9 notice of loss of entitlement within 90 days after the date of loss
 10 and pays the premium attributable to the period, effective as of the
 11 date of termination of entitlement, or equivalent coverage shall be
 12 provided if the prior form is no longer available.

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

25 (B) Reinstitution of coverages:

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

28 (ii) Shall provide for resumption of coverage that is substantially
 29 equivalent to coverage in effect before the date of suspension. If
 30 the suspended Medicare supplement policy provided coverage for
 31 outpatient prescription drugs, reinstatement of the policy for a
 32 Medicare Part D enrollee shall not include coverage for outpatient
 33 prescription drugs but shall otherwise provide coverage that is
 34 substantially equivalent to the coverage in effect before the date
 35 of suspension.

36 (iii) Shall provide for classification of premiums on terms at
 37 least as favorable to the policyholder or certificate holder as the
 38 premium classification terms that would have applied to the
 39 policyholder or certificate holder had the coverage not been
 40 suspended.

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

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

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

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

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

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

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. However, the benefits described in

paragraphs (6) and (7) shall not be offered so long as California is required to disallow these benefits for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under Section 1395ss of Title 42 of the United States Code.

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

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

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

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

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

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

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

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

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

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the

1 21st day to the 100th day, inclusive, in a Medicare benefit period
2 for posthospital skilled nursing facility care eligible under Medicare
3 Part A.

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

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

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

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

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

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

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

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

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

25 (i) Fecal occult blood test.

26 (ii) Mammogram.

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

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

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

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

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

5 (iii) “Home” shall mean any place used by the insured as a place
6 of residence, provided that the place would qualify as a residence
7 for home health care services covered by Medicare. A hospital or
8 skilled nursing facility shall not be considered the insured’s place
9 of residence.

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

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

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

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

23 (iii) Coverage is limited to the following:

24 (I) No more than the number and type of at-home recovery visits
25 certified as necessary by the insured’s attending physician. The
26 total number of at-home recovery visits shall not exceed the number
27 of Medicare-approved home health care visits under a
28 Medicare-approved home care plan of treatment.

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

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

33 (IV) Seven visits in any one week.

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

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

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

39 (VIII) At-home recovery visits received during the period the
40 insured is receiving Medicare-approved home care services or no

1 more than eight weeks after the service date of the last
2 Medicare-approved home health care visit.

3 (C) Coverage is excluded for the following:

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

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

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

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

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

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

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

29 (5) With respect to skilled nursing facility care, coverage for
30 50 percent of the coinsurance amount for each day used 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 until the out-of-pocket limitation described in paragraph
34 (10) is met.

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

39 (7) Coverage for 50 percent, under Medicare Part A or B, of
40 the reasonable cost of the first three pints of blood or equivalent

quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (10) is met.

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

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

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

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

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

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

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

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

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

1 (6) Except for coverage provided in paragraph (7), coverage for
2 75 percent of the cost sharing otherwise applicable under Medicare
3 Part B after the policyholder pays the Part B deductible until the
4 out-of-pocket limitation described in paragraph (8) is met.

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

8 (8) Coverage of 100 percent of the cost sharing for Medicare
9 Parts A and B for the balance of the calendar year after the
10 individual has reached the out-of-pocket limitation on annual
11 expenditures under Medicare Parts A and B of two thousand dollars
12 (\$2,000) in 2006, indexed each year by the appropriate inflation
13 adjustment specified by the secretary.

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

25 SEC. 19. Section 10192.81 is added to the Insurance Code, to
26 read:

27 10192.81. 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 standards. No issuer may offer any 1990 standardized
34 Medicare supplement benefit plan for sale with an effective date
35 on or after June 1, 2010. Benefit standards applicable to Medicare
36 supplement policies and certificates issued with an effective date
37 prior to June 1, 2010, remain subject to the requirements of Section
38 10192.8.

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

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

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

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

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

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

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

29 (B) The issuer shall not cancel or nonrenew the policy for any
30 reason other than nonpayment of premium or material
31 misrepresentation which is shown by the issuer to be material to
32 the acceptance for coverage. The contestability period for Medicare
33 supplement insurance shall be two years, pursuant to Section
34 ~~10305.2~~ 10350.2.

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

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

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

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

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

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

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

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

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

36 (7) (A) (i) A Medicare supplement policy or certificate shall
37 provide that benefits and premiums under the policy or certificate
38 shall be suspended at the request of the policyholder or certificate
39 holder for the period, not to exceed 24 months, in which the
40 policyholder or certificate holder has applied for and is determined

1 to be entitled to medical assistance under Medi-Cal, but only if
2 the policyholder or certificate holder notifies the issuer of the
3 policy or certificate within 90 days after the date the individual
4 becomes entitled to assistance. Upon receipt of timely notice, the
5 insurer shall return directly to the insured that portion of the
6 premium attributable to the period of Medi-Cal eligibility, subject
7 to adjustment for paid claims.

8 (ii) If suspension occurs and if the policyholder or certificate
9 holder loses entitlement to medical assistance under Medi-Cal, the
10 policy or certificate shall be automatically ~~reinstated, effective~~
11 *reinstated (effective* as of the date of termination of ~~entitlement,~~
12 *entitlement)* as of the termination of entitlement if the policyholder
13 or certificate holder provides notice of loss of entitlement within
14 90 days after the date of loss and pays the premium attributable to
15 the period, effective as of the date of termination of entitlement
16 or equivalent coverage shall be provided if the prior form is no
17 longer available.

18 (iii) Each Medicare supplement policy shall provide that benefits
19 and premiums under the policy shall be suspended (for any period
20 that may be provided by federal regulation) at the request of the
21 policyholder if the policyholder is entitled to benefits under Section
22 226(b) of the Social Security Act and is covered under a group
23 health plan (as defined in Section 1862(b)(1)(A)(v) of the Social
24 Security Act). If suspension occurs and if the policyholder or
25 certificate holder loses coverage under the group health plan, the
26 policy shall be automatically reinstated (effective as of the date
27 of loss of coverage) if the policyholder provides notice of loss of
28 coverage within 90 days after the date of the loss and pays the
29 applicable premium.

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

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

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

36 (iii) Provide for classification of premiums on terms at least as
37 favorable to the policyholder or certificate holder as the premium
38 classification terms that would have applied to the policyholder
39 or certificate holder had the coverage not been suspended.

1 (8) *A Medicare supplement policy shall not limit coverage*
2 *exclusively to a single disease or affliction.*

3 (9) *A Medicare supplement policy shall provide an examination*
4 *period of 30 days after the receipt of the policy by the applicant*
5 *for purposes of review, during which time the applicant may return*
6 *the policy as described in subdivision (e) of Section 10192.17.*

7 (b) With respect to the standards for basic (core) benefits for
8 benefit plans A, B, C, D, F, F with high deductible, G, M, and N,
9 every issuer of Medicare supplement insurance benefit plans shall
10 make available a policy or certificate including only the following
11 basic “core” package of benefits to each prospective insured. An
12 issuer may make available to prospective insureds any of the other
13 Medicare Supplement Insurance Benefit Plans in addition to the
14 basic (core) package, but not in lieu of it. However, the benefits
15 described in paragraphs (6) and (7) shall not be offered so long as
16 California is required to disallow these benefits for Medicare
17 beneficiaries by the centers for Medicare and Medicaid Services
18 or other agent of the federal government under Section 1395ss of
19 Title 42 of the United States Code.

20 (1) Coverage of Part A Medicare eligible expenses for
21 hospitalization to the extent not covered by Medicare from the
22 61st day through the 90th day, inclusive, in any Medicare benefit
23 period.

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

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

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

39 (5) Coverage for the coinsurance amount, or in the case of
40 hospital outpatient department services paid under a prospective

1 payment system, the copayment amount, of Medicare eligible
2 expenses under Part B regardless of hospital confinement, subject
3 to the Medicare Part B deductible.

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

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

9 (8) Coverage of the actual cost, up to the legally billed amount,
10 of an annual cervical cancer screening test as provided in Section
11 10123.18, to the extent not paid by Medicare.

12 (c) The following additional benefits shall be included in
13 Medicare supplement benefit plans B, C, D, F, F with high
14 deductible, G, M, and N, *consistent with the plan type and benefits*
15 *for each plan* as provided in Section 10192.91:

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

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

22 (3) With respect to skilled nursing facility care, coverage for
23 the actual billed charges up to the coinsurance amount from the
24 21st day through the 100th day in a Medicare benefit period for
25 posthospital skilled nursing facility care eligible under Medicare
26 Part A.

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

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

35 (6) With respect to medically necessary emergency care in a
36 foreign country, coverage to the extent not covered by Medicare
37 for 80 percent of the billed charges for Medicare-eligible expenses
38 for medically necessary emergency hospital, physician, and medical
39 care received in a foreign country, which care would have been
40 covered by Medicare if provided in the United States and which

1 care began during the first 60 consecutive days of each trip outside
2 the United States, subject to a calendar year deductible of \$250,
3 and a lifetime maximum benefit of \$50,000. For purposes of this
4 benefit, “emergency care” shall mean care needed immediately
5 because of an injury or an illness of sudden and unexpected onset.

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

8 10192.9. The following standards are applicable to all Medicare
9 supplement policies or certificates delivered or issued for delivery
10 in this state on or after July 1, 1992, and with an effective date
11 prior to June 1, 2010.

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

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

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

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

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

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

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

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

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

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

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

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on the calendar year, as

1 adjusted annually thereafter by the secretary to reflect the change
2 in the Consumer Price Index for all urban consumers for the
3 12-month period ending with August of the preceding year, and
4 rounded to the nearest multiple of ten dollars (\$10).

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

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

20 (10) Standardized Medicare supplement benefit plan I shall
21 consist of only the following: the core benefit, plus the Medicare
22 Part A deductible, skilled nursing facility care, 100 percent of the
23 Medicare Part B excess charges, basic outpatient prescription drug
24 benefit, medically necessary emergency care in a foreign country,
25 and at-home recovery benefit as defined in paragraphs (1), (2),
26 (5), (6), (8), and (10) of subdivision (c) of Section 10192.8,
27 respectively. The outpatient prescription drug benefit shall not be
28 included in a Medicare supplement policy sold on or after January
29 1, 2006.

30 (11) Standardized Medicare supplement benefit plan J shall
31 consist of only the following: the core benefit, plus the Medicare
32 Part A deductible, skilled nursing facility care, Medicare Part B
33 deductible, 100 percent of the Medicare Part B excess charges,
34 extended outpatient prescription drug benefit, medically necessary
35 emergency care in a foreign country, preventive medical care, and
36 at-home recovery benefit as defined in paragraphs (1), (2), (3),
37 (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8,
38 respectively. The outpatient prescription drug benefit shall not be
39 included in a Medicare supplement policy sold on or after January
40 1, 2006.

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

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

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

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

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

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

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

(2) If an issuer makes available any of the additional benefits described in subdivision (c) of Section 10192.81, or offers standardized benefit ~~Plans~~ *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~~ *plan* C, as described in paragraph (3) of subdivision (e), or standardized benefit ~~Plan~~ *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 makeup of 2010 standardized benefit plans, the following shall apply:

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

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

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

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

(6) Standardized Medicare supplement-~~Plan~~ *plan* F with high deductible shall include only the following: 100 percent of covered

1 expenses following the payment of the annual deductible set forth
2 in subparagraph (B).

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

11 (B) The annual deductible in ~~Plan~~ *plan* F with high deductible
12 shall consist of out-of-pocket expenses, other than premiums, for
13 services covered by ~~Plan~~ *plan* F, and shall be in addition to any
14 other specific benefit deductibles. The basis for the deductible
15 shall be one thousand five hundred dollars (\$1,500) and shall be
16 adjusted annually from 1999 by the Secretary of the United States
17 Department of Health and Human Services to reflect the change
18 in the Consumer Price Index for all urban consumers for the
19 12-month period ending with August of the preceding year, and
20 rounded to the nearest multiple of ten dollars (\$10).

21 (7) Standardized Medicare supplement benefit ~~Plan~~ *plan* G shall
22 include only the following: the basic (core) benefit as defined in
23 subdivision (b) of Section 10192.81, plus 100 percent of the
24 Medicare Part A deductible, skilled nursing facility care, 100
25 percent of the Medicare Part B excess charges, and medically
26 necessary emergency care in a foreign country, as defined in
27 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section
28 10192.81, respectively.

29 (8) Standardized Medicare supplement ~~Plan~~ *plan* K shall include
30 only the following:

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

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

37 (C) Upon exhaustion of the Medicare hospital inpatient
38 coverage, including the lifetime reserve days, coverage of 100
39 percent of the Medicare Part A eligible expenses for hospitalization
40 paid at the applicable prospective payment system (PPS) rate, or

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

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

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

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

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

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

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

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

37 (9) Standardized Medicare supplement ~~Plan~~ *plan* L shall include
38 only the following:

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

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

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

6 (10) Standardized Medicare supplement—~~Plan~~ *plan* M shall
7 include only the following: the basic (core) benefit as defined in
8 subdivision (b) of Section 10192.81, plus 50 percent of the
9 Medicare Part A deductible, skilled nursing facility care, and
10 medically necessary emergency care in a foreign country, as
11 defined in paragraphs (2), (3), and (6) of subdivision (c) of Section
12 10192.81, respectively.

13 (11) Standardized Medicare supplement—~~Plan~~ *plan* N shall
14 include only the following: the basic (core) benefit as defined in
15 subdivision (b) of Section 10192.81, plus 100 percent of the
16 Medicare Part A deductible, skilled nursing facility care, and
17 medically necessary emergency care in a foreign country, as
18 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
19 10192.81, respectively, with copayments in the following amounts:

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

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

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

1 SEC. 22. Section 10192.11 of the Insurance Code is amended
2 to read:

3 10192.11. (a) (1) An issuer shall not deny or condition the
4 issuance or effectiveness of any Medicare supplement policy or
5 certificate available for sale in this state, nor discriminate in the
6 pricing of a policy or certificate because of the health status, claims
7 experience, receipt of health care, or medical condition of an
8 applicant in the case of an application for a policy or certificate
9 that is submitted prior to or during the six-month period beginning
10 with the first day of the first month in which an individual is both
11 65 years of age or older and is enrolled for benefits under Medicare
12 Part B. Each Medicare supplement policy and certificate currently
13 available from an issuer shall be made available to all applicants
14 who qualify under this subdivision and who are 65 years of age
15 or older.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(h)~~

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

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

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

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

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

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

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

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

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

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

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

28 (J) (i) A 1990 standardized Medicare supplement benefit plan
29 J shall be deemed to offer benefits equal to those provided by a
30 2010 standardized Medicare supplement benefit plan F.

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

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

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

1 (M) Except as provided in clause (ii) of subparagraph (J), an
2 individual with a 1990 Medicare supplement policy with a high
3 deductible rider may choose only a 2010 standardized Medicare
4 supplement benefit Plan A.

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

10 SEC. 23. Section 10192.12 of the Insurance Code is amended
11 to read:

12 10192.12. (a) (1) With respect to the guaranteed issue of a
13 Medicare supplement policy, eligible persons are those individuals
14 described in subdivision (b) who seek to enroll under the policy
15 during the period specified in subdivision (c), and who submit
16 evidence of the date of termination or disenrollment or enrollment
17 in Medicare Part D with the application for a Medicare supplement
18 policy.

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

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

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

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

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

31 (1) The individual is enrolled under an employee welfare benefit
32 plan that provides health benefits that supplement the benefits
33 under Medicare, the plan either terminates or ceases to provide all
34 of those supplemental health benefits to the individual, and the
35 employer no longer provides the individual with insurance that
36 covers all of the payment for the 20-percent coinsurance.

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

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

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

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

14 (D) The Medicare Advantage plan in which the individual is
15 enrolled reduces any of its benefits or increases the amount of cost
16 sharing or discontinues for other than good cause relating to quality
17 of care, its relationship or contract under the plan with a provider
18 who is currently furnishing services to the individual. An individual
19 shall be eligible under this subparagraph for a Medicare supplement
20 policy issued by the same issuer through which the individual was
21 enrolled at the time the reduction, increase, or discontinuance
22 described above occurs or, commencing January 1, 2007, for one
23 issued by a subsidiary of the parent company of that issuer or by
24 a network that contracts with the parent company of that issuer.

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

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

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

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

38 (3) The individual is 65 years of age or older, is enrolled with
39 a Program of All-Inclusive Care for the Elderly (PACE) provider
40 under Section 1894 of the Social Security Act, and circumstances

1 similar to those described in paragraph (2) exist that would permit
2 discontinuance of the individual's enrollment with the provider,
3 if the individual were enrolled in a Medicare Advantage plan.

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

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

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

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

10 (iii) An organization under an agreement under Section
11 1833(a)(1)(A) of the Social Security Act (health care prepayment
12 plan).

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

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

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

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

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

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

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

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

38 (B) The subsequent enrollment under subparagraph (A) is
39 terminated by the individual during any period within the first 12
40 months of the subsequent enrollment (during which the enrollee

1 is permitted to terminate the subsequent enrollment under Section
2 1851(e) of the federal Social Security Act).

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

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

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

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

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

25 (2) In the case of an individual described in paragraphs (2), (3),
26 (4), (6), and (7) of subdivision (b) whose enrollment is terminated
27 involuntarily, the guaranteed issue period begins on the date that
28 the individual receives a notice of termination and ends 63 days
29 after the date the applicable coverage is terminated.

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

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

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

38 (4) In the case of an individual described in paragraph (2), (3),
39 (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of,
40 subdivision (b) who disenrolls voluntarily, the guaranteed issue

1 period begins on the date that is 60 days before the effective date
2 of the disenrollment and ends on the date that is 63 days after the
3 effective date of the disenrollment.

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

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

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

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

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

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

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

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

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

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

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

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement,

1 policy, or plan, the organization that offers the contract or
2 agreement, regardless of the basis for the cessation of enrollment,
3 the issuer offering the policy, or the administrator of the plan,
4 respectively, shall notify the individual of his or her rights under
5 this section, and of the obligations of issuers of Medicare
6 supplement policies under subdivision (a). The notice shall be
7 communicated within 10 working days of the date the issuer
8 received notification of disenrollment.

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

12 SEC. 24. Section 10192.13 of the Insurance Code is amended
13 to read:

14 10192.13. (a) An issuer shall comply with Section 1882(c)(3)
15 of the federal Social Security Act (as enacted by Section
16 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
17 of 1987 (OBRA), Public Law 100-203) by doing all of the
18 following and by certifying compliance on the Medicare
19 supplement insurance experience reporting form:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 SEC. 25. Section 10192.17 of the Insurance Code is amended
25 to read:

26 10192.17. (a) Medicare supplement policies and certificates
27 shall include a renewal, continuation, or conversion provision. The
28 language or specifications of the provision shall be consistent with
29 the type of contract issued. The provision shall be appropriately
30 captioned and shall appear on the first page of the policy, and shall
31 include any reservation by the issuer of the right to change
32 premiums and any automatic renewal premium increases based
33 on the policyholder's age.

34 (b) Except for riders or endorsements by which the issuer
35 effectuates a request made in writing by the insured, exercises a
36 specifically reserved right under a Medicare supplement policy,
37 or is required to reduce or eliminate benefits to avoid duplication
38 of Medicare benefits, all riders or endorsements added to a
39 Medicare supplement policy after the date of issue or upon
40 reinstatement or renewal that reduce or eliminate benefits or

1 coverage in the policy shall require a signed acceptance by the
2 insured. After the date of policy or certificate issue, any rider or
3 endorsement that increases benefits or coverage with a concomitant
4 increase in premium during the policy term shall be agreed to in
5 writing signed by the insured, unless the benefits are required by
6 the minimum standards for Medicare supplement policies, or if
7 the increased benefits or coverage is required by law. If a separate
8 additional premium is charged for benefits provided in connection
9 with riders or endorsements, the premium charge shall be set forth
10 in the policy.

11 (c) Medicare supplement policies or certificates shall not provide
12 for the payment of benefits based on standards described as “usual
13 and customary,” “reasonable and customary,” or words of similar
14 import.

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

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

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

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

38 (f) (1) Issuers of health insurance policies, certificates, or
39 contracts that provide hospital or medical expense coverage on an
40 expense incurred or indemnity basis, other than incidentally, to

persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the policy is delivered.

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

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

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

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

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

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

(j) (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline

1 of coverage properly describing the policy or certificate shall
2 accompany the policy or certificate when it is delivered and contain
3 the following statement, in no less than 12-point type, immediately
4 above the company name:

5
6 “NOTICE: Read this outline of coverage carefully. It is not
7 identical to the outline of coverage provided upon application and
8 the coverage originally applied for has not been issued.”
9

10 (2) The outline of coverage provided to applicants pursuant to
11 this section consists of four parts: a cover page, premium
12 information, disclosure pages, and charts displaying the features
13 of each benefit plan offered by the issuer. The outline of coverage
14 shall be in the language and format prescribed below in no less
15 than 12-point type. All Medicare supplement plans authorized by
16 federal law shall be shown on the cover page, and the plans that
17 are offered by the issuer shall be prominently identified. Premium
18 information for plans that are offered shall be shown on the cover
19 page or immediately following the cover page and shall be
20 prominently displayed. The premium and mode shall be stated for
21 all plans that are offered to the prospective applicant. All possible
22 premiums for the prospective applicant shall be illustrated.

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

28 (k) (1) Any disability insurance policy or certificate, a basic,
29 catastrophic or major medical expense policy, or single premium
30 nonrenewal policy or certificate issued to persons eligible for
31 Medicare, other than a Medicare supplement policy, a policy issued
32 pursuant to a contract under Section 1876 of the federal Social
33 Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income
34 policy, or any other policy identified in subdivision (b) of Section
35 10192.3, advertised, solicited, or issued for delivery in this state
36 to persons eligible for Medicare, shall notify insureds under the
37 policy that the policy is not a Medicare supplement policy or
38 certificate. The notice shall either be printed or attached to the first
39 page of the outline of coverage delivered to insureds under the
40 policy, or if no outline of coverage is delivered, to the first page

1 of the policy or certificate delivered to insureds. The notice shall
2 be in no less than 12-point type and shall contain the following
3 language:

4
5 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE
6 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible
7 for Medicare, review the Guide to Health Insurance for People
8 with Medicare available from the company.”
9

10 (2) Applications provided to persons eligible for Medicare for
11 the disability insurance policies or certificates described in
12 paragraph (1) shall disclose the extent to which the policy
13 duplicates Medicare in a manner required by the commissioner.
14 The disclosure statement shall be provided as a part of, or together
15 with, the application for the policy or certificate.

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

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

30 (2) If an outline of coverage is provided at or before the time
31 of application and the Medicare supplement policy or certificate
32 is issued on a basis that would require revision of the outline, a
33 substitute outline of coverage properly describing the policy or
34 certificate shall accompany the policy or certificate when it is
35 delivered and contain the following statement, in no less than
36 12-point type, immediately above the name:
37

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

1

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

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

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

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

18

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

23 The BASIC BENEFITS included in ALL plans are:

24 Hospitalization: Medicare Part A coinsurance plus coverage for
25 365 additional days after Medicare benefits end.

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

28 Blood: First three pints of blood each year.

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

31 Cervical cancer test: One annual screening.”

32

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

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

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

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

11
12 “Medicare supplement insurance can be sold in only standard
13 plans. This chart shows the benefits included in each plan. Every
14 insurance company must offer Plan A. Some plans may not be
15 available. Plans E, H, I and J are no longer available for sale. [This
16 sentence shall not appear after June 1, 2011.]

17 The BASIC BENEFITS included in ALL plans are:

18 Hospitalization: Medicare Part A coinsurance plus coverage for
19 365 additional days after Medicare benefits end.

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

24 Blood: First three pints of blood each year.

25 Hospice: Part A coinsurance.

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

28 Cervical cancer test: One annual screening.”

29
30 [Reference to the mammogram and cervical cancer screening
31 test shall not be included so long as California is required to
32 disallow them for Medicare beneficiaries by the Centers for
33 Medicare and Medicaid Services or other agent of the federal
34 government under 42 U.S.C. Sec. 1395ss.]

35 (B) PREMIUM INFORMATION. Premium information for
36 plans that are offered by the insurer shall be shown on, or
37 immediately following, the cover page and shall be clearly and
38 prominently displayed. The premium and mode shall be stated for
39 all offered plans. All possible premiums for the prospective
40 applicant shall be illustrated in writing. If the premium is based

1 on the increasing age of the insured, information specifying when
2 and how premiums will change shall be clearly illustrated in
3 writing. The text shall state: “We [the insurer’s name] can only
4 raise your premium if we raise the premium for all policies like
5 yours in California.”

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

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

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

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

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

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

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

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

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

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

19 SEC. 26. Section 10192.18 of the Insurance Code is amended
20 to read:

21 10192.18. (a) Application forms shall include the following
22 questions designed to elicit information as to whether, as of the
23 date of the application, the applicant currently has Medicare
24 supplement, Medicare Advantage, Medi-Cal coverage, or another
25 health insurance policy or certificate in force or whether a Medicare
26 supplement policy or certificate is intended to replace any other
27 disability policy or certificate presently in force. A supplementary
28 application or other form to be signed by the applicant and agent
29 containing those questions and statements may be used.

30
31 (Statements)
32

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

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

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

38 (4) If after purchasing this policy you become eligible for
39 Medi-Cal, the benefits and premiums under your Medicare
40 supplement policy can be suspended, if requested, during your

1 entitlement to benefits under Medi-Cal for 24 months. You must
2 request this suspension within 90 days of becoming eligible for
3 Medi-Cal. If you are no longer entitled to Medi-Cal, your
4 suspended Medicare supplement policy or if that is no longer
5 available, a substantially equivalent policy, will be reinstituted if
6 requested within 90 days of losing Medi-Cal eligibility. If the
7 Medicare supplement policy provided coverage for outpatient
8 prescription drugs and you enrolled in Medicare Part D while your
9 policy was suspended, the reinstituted policy will not have
10 outpatient prescription drug coverage, but will otherwise be
11 substantially equivalent to your coverage before the date of the
12 suspension.

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

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

(Questions)

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

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

To the best of your knowledge,

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

Yes____ No____

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

Yes____ No____

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

(2) Are you covered for medical assistance through California's Medi-Cal program

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

Yes____ No____

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement policy

Yes____ No____

(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

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

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy

Yes____ No____

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

Yes____ No____

- 1 (d) Did you drop a Medicare supplement policy to enroll in the
2 Medicare plan
3 Yes____ No____
- 4 (4) (a) Do you have another Medicare supplement policy in
5 force
6 Yes____ No____
- 7 (b) If so, with what company, and what plan do you have
8 [optional for direct mailers]
9 Yes____ No____
- 10 (c) If so, do you intend to replace your current Medicare
11 supplement policy with this policy
12 Yes____ No____
- 13 (5) Have you had coverage under any other health insurance
14 within the past 63 days (For example, an employer, union, or
15 individual plan)
16 Yes____ No____
- 17 (a) If so, with what companies and what kind of policy
18 _____
19 _____
20 _____
21 _____
- 22 (b) What are your dates of coverage under the other policy
23 START __/__/__ END __/__/__
24 (If you are still covered under the other policy, leave “END”
25 blank.)
- 26
- 27 (b) Agents shall list any other health insurance policies they
28 have sold to the applicant as follows:
- 29 (1) List policies sold that are still in force.
30 (2) List policies sold in the past five years that are no longer in
31 force.
- 32 (c) In the case of a direct response issuer, a copy of the
33 application or supplemental form, signed by the applicant, and
34 acknowledged by the issuer, shall be returned to the applicant by
35 the issuer upon delivery of the policy.
- 36 (d) Upon determining that a sale will involve replacement of
37 Medicare supplement coverage, any issuer, other than a direct
38 response issuer, or its agent, shall furnish the applicant, prior to
39 issuance for delivery of the Medicare supplement policy or
40 certificate, a notice regarding replacement of Medicare supplement

coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer as provided in Section 10508. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be in the form specified by the commissioner, using, to the extent practicable, a model notice prepared by the National Association of Insurance Commissioners for this purpose. The replacement notice shall be printed in no less than 12-point type in substantially the following form:

[Insurer's name and address]

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

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

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

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

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

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

10 ___ Additional benefits that are: _____
11 ___ No change in benefits, but lower premiums.
12 ___ Fewer benefits and lower premiums.
13 ___ Plan has outpatient prescription drug coverage and applicant
14 is enrolled in Medicare Part D.

15 ___ Disenrollment from a Medicare Advantage plan. Reasons for
16 disenrollment:

17 ___ Other reasons specified here: _____

18 1. Note: If the issuer of the Medicare supplement policy being
19 applied for does not impose, or is otherwise prohibited from
20 imposing, preexisting condition limitations, please skip to statement
21 3 below. Health conditions that you may presently have
22 (preexisting conditions) may not be immediately or fully covered
23 under the new policy. This could result in denial or delay of a claim
24 for benefits under the new policy, whereas a similar claim might
25 have been payable under your present policy.

26 2. State law provides that your replacement Medicare supplement
27 policy may not contain new preexisting conditions, waiting periods,
28 elimination periods, or probationary periods. The insurer will waive
29 any time periods applicable to preexisting conditions, waiting
30 periods, elimination periods, or probationary periods in the new
31 coverage for similar benefits to the extent that time was spent
32 (depleted) under the original policy.

33 3. If you still wish to terminate your present policy and replace
34 it with new coverage, be certain to truthfully and completely
35 answer any and all questions on the application concerning your
36 medical and health history. Failure to include all material medical
37 information on an application requesting that information may
38 provide a basis for the insurer to deny any future claims and to
39 refund your premium as though your policy had never been in
40 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)

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

(g) For an individual who is subject to an open enrollment period or who is guaranteed issuance of any Medicare supplement coverage as described in Section 10192.11 or 10192.12, an issuer ~~shall not require or use, for the purpose of determining eligibility or premium levels, or for any other purpose not explicitly disclosed to the applicant pursuant to this subdivision, the applicant's health information, including health information acquired in compliance with the federal Health Insurance Portability and Accountability Act of 1996, or require an applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. A statement of this prohibition shall be included on the application form in clear and conspicuous language, in addition to the open enrollment and guaranteed issue periods described in Sections 10192.11 and 10192.12. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage. This subdivision shall not preclude an issuer from requesting an applicant to voluntarily provide health information, provided that the issuer obtains authorization in compliance with the applicable requirements under the federal Health Insurance Portability and~~

~~Accountability Act of 1996. shall not require or request health information from an applicant or require or request the applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996 during a period of open enrollment or guaranteed issuance, as described in Section 10192.11 or 10192.12, of any Medicare supplement coverage and shall inform the applicant of the periods of open enrollment or guaranteed issuance of Medicare supplement coverage. A supplementary application or other form containing those statements that the applicant and solicitor are required to sign may be used for this purpose. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.~~

SEC. 27. Section 10192.20 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (1) (A) For policies sold for effective dates prior to June 1,
28 2010, a listing of all the policies, plans A to L, inclusive, that are
29 available from the company.

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

34 (2) (A) For policies sold for effective dates prior to June 1,
35 2010, a listing of all the policies, plans A to L, inclusive, for
36 Medicare beneficiaries under the age of 65 that are available from
37 the company.

38 (B) For policies sold for effective dates on or after June 1, 2010,
39 a listing of all the policies, plans, A to D, inclusive, F, F with high

deductible, G, and K to N, inclusive, for Medicare beneficiaries under the age 65 that are available from the company.

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

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

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

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

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

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

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

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

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

SEC. 28. Section 10192.24 is added to the Insurance Code, to read:

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

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

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

6 (2) The issuer shall not discriminate in the pricing of the policy
7 or certificate, including the adjustment of premium rates, of an
8 individual on the basis of the genetic information with respect to
9 that individual or a family member of the individual.

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

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

16 (2) Increase the premium for any policy issued to an individual
17 based on the manifestation of a disease or disorder of an individual
18 who is covered under the policy. For purposes of this paragraph,
19 the manifestation of a disease or disorder in one individual shall
20 not also be used as genetic information about other group members
21 and to further increase the premium for the group.

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

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

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

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

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

6 (h) If an issuer of a Medicare supplement policy or certificate
7 obtains genetic information incidental to the requesting, requiring,
8 or purchasing of other information concerning any individual or
9 a family member of that individual, the request, requirement, or
10 purchase shall not be considered a violation of subdivision (g) if
11 the request, requirement, or purchase is not in violation of
12 subdivision (f). However, the issuer shall not use any genetic
13 information obtained under this section for any prohibited purpose
14 described in this section or in Sections 10140 and 10143.

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

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

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

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

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

1 (5) “Genetic test” means an analysis of human DNA, RNA,
2 chromosomes, proteins, or metabolites, that detect genotypes,
3 mutations, or chromosomal changes. The term “genetic test” does
4 not mean an analysis of proteins or metabolites that does not detect
5 genotypes, mutations, or chromosomal changes; or an analysis of
6 proteins or metabolites that is directly related to a manifested
7 disease, disorder, or pathological condition that could reasonably
8 be detected by a health care professional with appropriate training
9 and expertise in the field of medicine involved.

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

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

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

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

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

19 SEC. 29. No reimbursement is required by this act pursuant to
20 Section 6 of Article XIII B of the California Constitution because
21 the only costs that may be incurred by a local agency or school
22 district will be incurred because this act creates a new crime or
23 infraction, eliminates a crime or infraction, or changes the penalty
24 for a crime or infraction, within the meaning of Section 17556 of
25 the Government Code, or changes the definition of a crime within
26 the meaning of Section 6 of Article XIII B of the California
27 Constitution.

28 SEC. 30. This act is an urgency statute necessary for the
29 immediate preservation of the public peace, health, or safety within
30 the meaning of Article IV of the Constitution and shall go into
31 immediate effect. The facts constituting the necessity are:

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