AMENDED IN SENATE JUNE 11, 2009

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)~~*Assembly Members Jones and Fletcher*

(Coauthors: Assembly Members 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~~ *Jones*. Medicare supplement ~~coverage: Medicare Advantage plans.~~ *coverage.*

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

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~~ *contract or policy* if the person is enrolled under an employee welfare benefit plan that provides health

benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.

This bill would provide that a person is eligible for the guaranteed issue of a Medicare supplement ~~plan~~ *contract or policy* 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 provides the individual with insurance that covers all of the payment for the 20% coinsurance.

Existing law prohibits an issuer from denying or conditioning the issuance of a Medicare supplement contract or policy because of, among other things, the health status of the applicant during certain open enrollment periods, as specified. 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). *Existing law requires the application form to include a statement that the applicant is not required to provide health information or sign a form required by HIPAA during a period of guaranteed issuance.*

This bill would prohibit an issuer from requiring, requesting, or obtaining health information from an applicant who is guaranteed issuance of, or open enrollment for, Medicare supplement coverage, except as specified, and would require the application form to include a statement that the applicant is not required to provide health information during a period where guaranteed issue or open enrollment applies.

~~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 an entity that 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: ⅔. 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) An entity that undertakes to arrange for the~~
4 ~~provision of health care services in this state under the Medicare~~
5 ~~Advantage program pursuant to Part C (commencing with Section~~
6 ~~1395w-21) of Title XVIII of Chapter 7 of Title 42 of the United~~
7 ~~States Code shall be licensed under this chapter and shall comply~~
8 ~~with all requirements under this chapter except to the extent~~
9 ~~preempted by federal law.~~
10 ~~(b) Any arrangement for health care services other than that~~
11 ~~specified in subdivision (a) shall comply with all of the~~
12 ~~requirements of this chapter to the extent applicable.~~
13 ~~SEC. 2.~~
14 *SECTION 1.* 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.

1 (2) An enrollee who seeks to obtain health coverage through a
2 group, in the case of a group Medicare supplement contract.
3 (b) "Bankruptcy" means that situation in which a Medicare
4 Advantage organization that is not an issuer has filed, or has had
5 filed against it, a petition for declaration of bankruptcy and has
6 ceased doing business in the state.
7 (c) "Continuous period of creditable coverage" means the period
8 during which an individual was covered by creditable coverage,
9 if during the period of the coverage the individual had no breaks
10 in coverage greater than 63 days.
11 (d) (1) "Creditable coverage" means, with respect to an
12 individual, coverage of the individual provided under any of the
13 following:
14 (A) Any individual or group contract, policy, certificate, or
15 program that is written or administered by a health care service
16 plan, health insurer, fraternal benefits society, self-insured
17 employer plan, or any other entity, in this state or elsewhere, and
18 that arranges or provides medical, hospital, and surgical coverage
19 not designed to supplement other private or governmental plans.
20 The term includes continuation or conversion coverage.
21 (B) Part A or B of Title XVIII of the federal Social Security
22 Act (Medicare).
23 (C) Title XIX of the federal Social Security Act (medicaid),
24 other than coverage consisting solely of benefits under Section
25 1928 of that act.
26 (D) Chapter 55 of Title 10 of the United States Code
27 (CHAMPUS).
28 (E) A medical care program of the Indian Health Service or of
29 a tribal organization.
30 (F) A state health benefits risk pool.
31 (G) A health plan offered under Chapter 89 of Title 5 of the
32 United States Code (Federal Employees Health Benefits Program).
33 (H) A public health plan as defined in federal regulations
34 authorized by Section 2701(c)(1)(I) of the federal Public Health
35 Service Act, as amended by Public Law 104-191, the federal Health
36 Insurance Portability and Accountability Act of 1996.
37 (I) A health benefit plan under Section 5(e) of the federal Peace
38 Corps Act (Section 2504(e) of Title 22 of the United States Code).
39 (J) Any other publicly sponsored program, provided in this state
40 or elsewhere, of medical, hospital, and surgical care.

1 (K) Any other creditable coverage as defined by subsection (c)
2 of Section 2701 of Title XXVII of the federal Public Health
3 Services Act (42 U.S.C. Sec. 300gg(c)).
4 (2) "Creditable coverage" shall not include one or more, or any
5 combination of, the following:
6 (A) Coverage for accident-only or disability income insurance,
7 or any combination thereof.
8 (B) Coverage issued as a supplement to liability insurance.
9 (C) Liability insurance, including general liability insurance
10 and automobile liability insurance.
11 (D) Workers' compensation or similar insurance.
12 (E) Automobile medical payment insurance.
13 (F) Credit-only insurance.
14 (G) Coverage for onsite medical clinics.
15 (H) Other similar insurance coverage, specified in federal
16 regulations, under which benefits for medical care are secondary
17 or incidental to other insurance benefits.
18 (3) "Creditable coverage" shall not include the following
19 benefits if they are provided under a separate policy, certificate,
20 or contract or are otherwise not an integral part of the plan:
21 (A) Limited scope dental or vision benefits.
22 (B) Benefits for long-term care, nursing home care, home health
23 care, community-based care, or any combination thereof.
24 (C) Other similar, limited benefits as are specified in federal
25 regulations.
26 (4) "Creditable coverage" shall not include the following
27 benefits if offered as independent, noncoordinated benefits:
28 (A) Coverage only for a specified disease or illness.
29 (B) Hospital indemnity or other fixed indemnity insurance.
30 (5) "Creditable coverage" shall not include the following if
31 offered as a separate policy, certificate, or contract:
32 (A) Medicare supplemental health insurance as defined under
33 Section 1882(g)(1) of the federal Social Security Act.
34 (B) Coverage supplemental to the coverage provided under
35 Chapter 55 of Title 10 of the United States Code.
36 (C) Similar supplemental coverage provided to coverage under
37 a group health plan.
38 (e) "Employee welfare benefit plan" means a plan, fund, or
39 program of employee benefits as defined in Section 1002 of Title

1 29 of the United States Code (Employee Retirement Income
2 Security Act).
3 (f) "Insolvency" means when an issuer, licensed to transact the
4 business of a health care service plan in this state, has had a final
5 order of liquidation entered against it with a finding of insolvency
6 by a court of competent jurisdiction in the issuer's state of domicile.
7 (g) "Issuer" means a health care service plan delivering, or
8 issuing for delivery, Medicare supplement contracts in this state,
9 but does not include entities subject to Article 6 (commencing with
10 Section 10192.1) of Chapter 1 of Division 2 of the Insurance Code.
11 (h) "Medicare" means the federal Health Insurance for the Aged
12 Act, Title XVIII of the Social Security Amendments of 1965, as
13 amended.
14 (i) "Medicare Advantage Plan" means a plan of coverage for
15 health benefits under Medicare Part C and includes:
16 (1) Coordinated care plans that provide health care services,
17 including, but not limited to, health care service plans (with or
18 without a point-of-service option), plans offered by
19 provider-sponsored organizations, and preferred provider
20 organizations plans.
21 (2) Medical savings account plans coupled with a contribution
22 into a Medicare Advantage medical savings account.
23 (3) Medicare Advantage private fee-for-service plans.
24 (j) "Medicare supplement contract" means a group or individual
25 plan contract of hospital and medical service associations or health
26 care service plans, other than a contract issued pursuant to a
27 contract under Section 1876 of the federal Social Security Act (42
28 U.S.C.A. Section 1395mm) or an issued contract under a
29 demonstration project specified in Section 1395ss(g)(1) of Title
30 42 of the United States Code, that is advertised, marketed, or
31 designed primarily as a supplement to reimbursements under
32 Medicare for the hospital, medical, or surgical expenses of persons
33 eligible for Medicare. "Contract" means "Medicare supplement
34 contract," unless the context requires otherwise. "Medicare
35 supplement contract" does not include a Medicare Advantage plan
36 established under Medicare Part C, an outpatient prescription drug
37 plan established under Medicare Part D, or a health care
38 prepayment plan that provides benefits pursuant to an agreement
39 under subparagraph (A) of paragraph (1) of subsection (a) of
40 Section 1833 of the Social Security Act.

1 (k) "1990 standardized Medicare supplement benefit plan,"
2 "1990 standardized benefit plan," or "1990 plan" means a group
3 or individual Medicare supplement contract issued on or after July
4 21, 1992, and with an effective date prior to June 1, 2010, and
5 includes Medicare supplement contracts renewed on or after that
6 date that are not replaced by the issuer at the request of the enrollee
7 or subscriber.
8 (*l*) "2010 standardized Medicare supplement benefit plan,"
9 "2010 standardized benefit plan," or "2010 plan" means a group
10 or individual Medicare supplement contract issued with an effective
11 date on or after June 1, 2010.
12 (m) "Secretary" means the Secretary of the United States
13 Department of Health and Human Services.
14 ~~SEC. 3.~~
15 *SEC. 2.* Section 1358.6 of the Health and Safety Code is
16 amended to read:
17 1358.6. (a) (1) Except for permitted preexisting condition
18 clauses as described in Sections 1358.7, 1358.8, and 1358.81, a
19 contract shall not be advertised, solicited, or issued for delivery
20 as a Medicare supplement contract if the contract contains
21 definitions, limitations, exclusions, conditions, reductions, or other
22 provisions that are more restrictive or limiting than that term as
23 officially used in Medicare, except as expressly authorized by this
24 article.
25 (2) No issuer may advertise, solicit, or issue for delivery any
26 Medicare supplement contract with hospital or medical coverage
27 if the contract contains any of the prohibited provisions described
28 in subdivision (b).
29 (b) The following provisions shall be deemed to be unfair,
30 unreasonable, and inconsistent with the objectives of this chapter
31 and shall not be contained in any Medicare supplement contract:
32 (1) Any waiver, exclusion, limitation, or reduction based on or
33 relating to a preexisting disease or physical condition, unless that
34 waiver, exclusion, limitation, or reduction (A) applies only to
35 coverage for specified services rendered not more than six months
36 from the effective date of coverage, (B) is based on or relates only
37 to a preexisting disease or physical condition defined no more
38 restrictively than a condition for which medical advice was given
39 or treatment was recommended by or received from a physician
40 within six months before the effective date of coverage, (C) does

not apply to any coverage under any group contract, and (D) is approved in advance by the director. Any limitations with respect to a preexisting condition shall appear as a separate paragraph of 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.~~

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

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

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

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

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

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

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

(C) If a group Medicare supplement contract is terminated by the subscriber and is not replaced as provided under subparagraph (E), the issuer shall offer enrollees an individual Medicare supplement contract that, at the option of the enrollee, either

1 provides for continuation of the benefits contained in the terminated
2 contract or provides for benefits that otherwise meet the
3 requirements of this subsection.
4 (D) If an individual is an enrollee in a group Medicare
5 supplement contract and the individual membership in the group
6 is terminated, the issuer shall either offer the enrollee the
7 conversion opportunity described in subparagraph (C) or, at the
8 option of the subscriber, shall offer the enrollee continuation of
9 coverage under the group contract.
10 (E) If a group Medicare supplement contract is replaced by
11 another group Medicare supplement contract purchased by the
12 same subscriber, the issuer of the replacement contract shall offer
13 coverage to all persons covered under the old group contract on
14 its date of termination. Coverage under the new contract shall not
15 result in any exclusion for preexisting conditions that would have
16 been covered under the group contract being replaced.
17 (F) If a Medicare supplement contract eliminates an outpatient
18 prescription drug benefit as a result of requirements imposed by
19 the Medicare Prescription Drug, Improvement, and Modernization
20 Act of 2003 (Public Law 108-173), the contract as modified as a
21 result of that act shall be deemed to satisfy the guaranteed renewal
22 requirements of this paragraph.
23 (6) Termination of a Medicare supplement contract shall be
24 without prejudice to any continuous loss that commenced while
25 the contract was in force, but the extension of benefits beyond the
26 period during which the contract was in force may be predicated
27 upon the continuous total disability of the covered person, limited
28 to the duration of the contract benefit period, if any, or to payment
29 of the maximum benefits. Receipt of Medicare Part D benefits
30 shall not be considered in determining a continuous loss.
31 (7) (A) (i) A Medicare supplement contract shall provide that
32 benefits and prepaid or periodic charges under the contract shall
33 be suspended at the request of the enrollee for the period, not to
34 exceed 24 months, in which the enrollee has applied for and is
35 determined to be entitled to medical assistance under Title XIX
36 of the federal Social Security Act, but only if the enrollee notifies
37 the issuer of the contract within 90 days after the date the individual
38 becomes entitled to assistance.
39 If suspension occurs and if the enrollee loses entitlement to
40 medical assistance, the contract shall be automatically reinstituted

(effective as of the date of termination of entitlement) as of the termination of entitlement if the enrollee provides notice of loss of entitlement within 90 days after the date of loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement. Upon receipt of timely notice, the issuer shall return directly to the enrollee that portion of the prepaid or periodic charge attributable to the period the enrollee was entitled to medical assistance, subject to adjustment for paid claims.

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

(B) Reinstitution of coverages:

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

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

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

(8) If an issuer makes a written offer to the Medicare supplement enrollee or subscriber of one or more of its plan contracts, to exchange during a specified period from his or her 1990 standardized plan, as described in Section 1358.9, to a 2010

1 standardized plan, as described in Section 1358.91, the offer and
2 subsequent exchange shall comply with the following requirements:
3 (A) An issuer need not provide justification to the director if
4 the enrollee or subscriber replaces a 1990 standardized plan
5 contract with an issue age rated 2010 standardized plan contract
6 at the enrollee or subscriber's original issue age and duration. If
7 an enrollee or subscriber's plan contract to be replaced is priced
8 on an issue age rate schedule at the time of that offer, the rate
9 charged to the enrollee or subscriber for the new exchanged plan
10 shall recognize the plan contract reserve buildup, due to the
11 prefunding inherent in the use of an issue age rate basis, for the
12 benefit of the enrollee or subscriber. The method proposed to be
13 used by an issuer shall be filed with the director.
14 (B) The rating class of the new plan contract shall be the class
15 closest to the enrollee or subscriber's class of the replaced
16 coverage.
17 (C) An issuer may not apply new preexisting condition
18 limitations or a new incontestability period to the new plan contract
19 for those benefits contained in the exchanged 1990 standardized
20 plan contract of the enrollee or subscriber, but may apply
21 preexisting condition limitations of no more than six months to
22 any added benefits contained in the new 2010 standardized plan
23 contract not contained in the exchanged plan contract. This
24 subdivision shall not apply to an applicant who is guaranteed issue
25 under Section 1358.11 or 1358.12.
26 (D) The new plan contract shall be offered to all enrollees or
27 subscribers within a given plan, except where the offer or issue
28 would be in violation of state or federal law.
29 (9) A Medicare supplement contract shall not be limited to
30 coverage for a single disease or affliction.
31 (10) A Medicare supplement contract shall provide an
32 examination period of 30 days after the receipt of the contract by
33 the applicant for purposes of review, during which time the
34 applicant may return the contract as described in subdivision (e)
35 of Section 1358.17.
36 (11) A Medicare supplement contract shall additionally meet
37 any other minimum benefit standards as established by the director.
38 (12) Within 30 days prior to the effective date of any Medicare
39 benefit changes, an issuer shall file with the director, and notify

its subscribers and enrollees of, modifications it has made to Medicare supplement contracts.

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

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

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

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

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

(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 applicable prospective payment system rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the enrollee or subscriber 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 services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

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

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

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

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

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

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

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

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

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

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

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

(i) Fecal occult blood test.

(ii) Mammogram.

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

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMACPT) codes, to a maximum of one hundred twenty dollars ($120) annually

under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

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

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

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

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

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

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

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

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

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

(iii) Coverage is limited to the following:

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

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.
(III) One thousand six hundred dollars ($1,600) per calendar year.
(IV) Seven visits in any one week.
(V) Care furnished on a visiting basis in the insured's home.
(VI) Services provided by a care provider as defined in subparagraph (A).
(VII) At-home recovery visits while the covered person is covered under the contract and not otherwise excluded.
(VIII) At-home recovery visits received during the period the covered person is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.
(C) Coverage is excluded for the following:
(i) Home care visits paid for by Medicare or other government programs.
(ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.
(d) The standardized Medicare supplement benefit plan "K" shall consist of the following benefits:
(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.
(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.
(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment for this benefit as payment in full and shall not bill the enrollee or subscriber for any balance.
(4) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (10) is met.

1 (5) With respect to skilled nursing facility care, coverage for
2 50 percent of the coinsurance amount for each day used from the
3 21st day to the 100th day, inclusive, in a Medicare benefit period
4 for posthospital skilled nursing facility care eligible under Medicare
5 Part A until the out-of-pocket limitation described in paragraph
6 (10) is met.
7 (6) With respect to hospice care, coverage for 50 percent of cost
8 sharing for all Medicare Part A eligible expenses and respite care
9 until the out-of-pocket limitation described in paragraph (10) is
10 met.
11 (7) Coverage for 50 percent, under Medicare Part A or B, of
12 the reasonable cost of the first three pints of blood or equivalent
13 quantities of packed red blood cells, as defined under federal
14 regulations, unless replaced in accordance with federal regulations,
15 until the out-of-pocket limitation described in paragraph (10) is
16 met.
17 (8) Except for coverage provided in paragraph (9), coverage for
18 50 percent of the cost sharing otherwise applicable under Medicare
19 Part B after the enrollee or subscriber pays the Part B deductible,
20 until the out-of-pocket limitation is met as described in paragraph
21 (10).
22 (9) Coverage of 100 percent of the cost sharing for Medicare
23 Part B preventive services, after the enrollee or subscriber pays
24 the Medicare Part B deductible.
25 (10) Coverage of 100 percent of all cost sharing under Medicare
26 Parts A and B for the balance of the calendar year after the
27 individual has reached the out-of-pocket limitation on annual
28 expenditures under Medicare Parts A and B of four thousand
29 dollars ($4,000) in 2006, indexed each year by the appropriate
30 inflation adjustment specified by the secretary.
31 (e) The standardized Medicare supplement benefit plan “L”
32 shall consist of the following benefits:
33 (1) The benefits described in paragraphs (1), (2), (3), and (9) of
34 subdivision (d).
35 (2) With respect to the Medicare Part A deductible, coverage
36 for 75 percent of the Medicare Part A inpatient hospital deductible
37 amount per benefit period until the out-of-pocket limitation
38 described in paragraph (8) is met.
39 (3) With respect to skilled nursing facility care, coverage for
40 75 percent of the coinsurance amount for each day used from the

21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (8) is met.

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

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

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the 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.~~

SEC. 4. 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

1 state as a Medicare supplement contract unless it complies with
2 these benefit standards. No issuer may offer any 1990 standardized
3 Medicare supplement contract for sale with an effective date on
4 or after June 1, 2010. Benefit standards applicable to Medicare
5 supplement contracts issued with an effective date before June 1,
6 2010, remain subject to the requirements of Section 1358.8.
7 (a) The following general standards apply to Medicare
8 supplement contracts and are in addition to all other requirements
9 of this article.
10 (1) A Medicare supplement contract shall not exclude or limit
11 benefits for losses incurred more than six months from the effective
12 date of coverage because it involved a preexisting condition. The
13 contract shall not define a preexisting condition more restrictively
14 than a condition for which medical advice was given or treatment
15 was recommended by, or received from, a physician within six
16 months before the effective date of coverage.
17 (2) A Medicare supplement contract shall not indemnify against
18 losses resulting from sickness on a different basis than losses
19 resulting from accidents.
20 (3) A Medicare supplement contract shall provide that benefits
21 designed to cover cost-sharing amounts under Medicare will be
22 changed automatically to coincide with any changes in the
23 applicable Medicare deductible, copayment, or coinsurance
24 amounts. Prepaid or periodic charges may be modified to
25 correspond with those changes.
26 (4) A Medicare supplement contract shall not provide for
27 termination of coverage of a spouse solely because of the
28 occurrence of an event specified for termination of coverage of
29 the enrollee or subscriber, other than the nonpayment of prepaid
30 or periodic charges.
31 (5) Each Medicare supplement contract shall be guaranteed
32 renewable.
33 (A) The issuer shall not cancel or nonrenew the contract solely
34 on the ground of health status of the individual.
35 (B) The issuer shall not cancel or nonrenew the contract for any
36 reason other than nonpayment of prepaid or periodic charges or
37 misrepresentation of the risk by the applicant that is shown by the
38 plan to be material to the acceptance for coverage. The
39 contestability period for Medicare supplement contracts shall be
40 two years.

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

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

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

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

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

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

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

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

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

1 (7) (A) (i) A Medicare supplement contract shall provide that
2 benefits and prepaid or periodic charges under the contract shall
3 be suspended at the request of the enrollee or subscriber for the
4 period, not to exceed 24 months, in which the enrollee or subscriber
5 has applied for, and is determined to be entitled to, medical
6 assistance under Medi-Cal under Title XIX of the federal Social
7 Security Act, but only if the enrollee or subscriber notifies the
8 issuer of the contract within 90 days after the date the individual
9 becomes entitled to assistance. Upon receipt of timely notice, the
10 insurer shall return directly to the enrollee or subscriber that portion
11 of the prepaid or periodic charge attributable to the period of
12 Medi-Cal eligibility, subject to adjustment for paid claims.
13 (ii) If suspension occurs and if the enrollee or subscriber loses
14 entitlement to medical assistance under Medi-Cal, the Medicare
15 supplement contract shall be automatically reinstituted (effective
16 as of the date of termination of entitlement) as of the termination
17 of entitlement if the enrollee or subscriber provides notice of loss
18 of entitlement within 90 days after the date of loss and pays the
19 prepaid or periodic charge attributable to the period, effective as
20 of the date of termination of entitlement or equivalent coverage
21 shall be provided if the prior contract is no longer available.
22 (iii) Each Medicare supplement contract shall provide that
23 benefits and prepaid or periodic charges under the contract shall
24 be suspended (for any period that may be provided by federal
25 regulation) at the request of the enrollee or subscriber if the enrollee
26 or subscriber is entitled to benefits under Section 226(b) of the
27 Social Security Act and is covered under a group health plan (as
28 defined in Section 1862(b)(1)(A)(v) of the Social Security Act).
29 If suspension occurs and if the enrollee or subscriber loses coverage
30 under the group health plan, the contract shall be automatically
31 reinstituted (effective as of the date of loss of coverage) if the
32 enrollee or subscriber provides notice of loss of coverage within
33 90 days after the date of the loss and pays the applicable prepaid
34 or periodic charge.
35 (B) Reinstitution of coverages shall comply with all of the
36 following requirements:
37 (i) Not provide for any waiting period with respect to treatment
38 of preexisting conditions.
39 (ii) Provide for resumption of coverage that is substantially
40 equivalent to coverage in effect before the date of suspension.

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

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

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

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

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

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

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

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

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

(b) With respect to the standards for basic (core) benefits for benefit plans A, B, C, D, F, ~~F with high deductible~~ *high deductible F*, G, M, and N, every issuer of Medicare supplement benefit plans shall make available a contract including only the following basic "core" package of benefits to each prospective enrollee or subscriber. An issuer may make available to prospective enrollees or subscribers any of the other Medicare supplement benefit plans

in addition to the basic core package, but not in lieu of that package.

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

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

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

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

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

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

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

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

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

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

21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

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

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

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

~~SEC. 6.~~

SEC. 5. Section 1358.9 of the Health and Safety Code is amended to read:

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

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

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

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A to J, inclusive, listed in subdivision (e), and shall conform to the

1 definitions in Section 1358.4. Each benefit shall be structured in
2 accordance with the format provided in subdivisions (b), (c), (d),
3 and (e) of Section 1358.8 and list the benefits in the order listed
4 in subdivision (e). For purposes of this section, "structure,
5 language, and format" means style, arrangement, and overall
6 content of a benefit.
7 (d) An issuer may use, in addition to the benefit plan
8 designations required in subdivision (c), other designations to the
9 extent permitted by law.
10 (e) With respect to the makeup of benefit plans, the following
11 shall apply:
12 (1) Standardized Medicare supplement benefit plan A shall be
13 limited to the basic (core) benefit common to all benefit plans, as
14 defined in subdivision (b) of Section 1358.8.
15 (2) Standardized Medicare supplement benefit plan B shall
16 include only the following: the core benefit, plus the Medicare
17 Part A deductible as defined in paragraph (1) of subdivision (c) of
18 Section 1358.8.
19 (3) Standardized Medicare supplement benefit plan C shall
20 include only the following: the core benefit, plus the Medicare
21 Part A deductible, skilled nursing facility care, Medicare Part B
22 deductible, and medically necessary emergency care in a foreign
23 country as defined in paragraphs (1), (2), (3), and (8) of subdivision
24 (c) of Section 1358.8, respectively.
25 (4) Standardized Medicare supplement benefit plan D shall
26 include only the following: the core benefit, plus the Medicare
27 Part A deductible, skilled nursing facility care, medically necessary
28 emergency care in a foreign country, and the at-home recovery
29 benefit as defined in paragraphs (1), (2), (8), and (10) of
30 subdivision (c) of Section 1358.8, respectively.
31 (5) Standardized Medicare supplement benefit plan E shall
32 include only the following: the core benefit, plus the Medicare
33 Part A deductible, skilled nursing facility care, medically necessary
34 emergency care in a foreign country, and preventive medical care
35 as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of
36 Section 1358.8, respectively.
37 (6) Standardized Medicare supplement benefit plan F shall
38 include only the following: the core benefit, plus the Medicare
39 Part A deductible, the skilled nursing facility care, the Medicare
40 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.

(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

1 Medicare Part B excess charges, basic outpatient prescription drug
2 benefit, medically necessary emergency care in a foreign country,
3 and at-home recovery benefit as defined in paragraphs (1), (2),
4 (5), (6), (8), and (10) of subdivision (c) of Section 1358.8,
5 respectively. The outpatient prescription drug benefit shall not be
6 included in a Medicare supplement contract sold on or after January
7 1, 2006.
8 (11) Standardized Medicare supplement benefit plan J shall
9 consist of only the following: the core benefit, plus the Medicare
10 Part A deductible, skilled nursing facility care, Medicare Part B
11 deductible, 100 percent of the Medicare Part B excess charges,
12 extended outpatient prescription drug benefit, medically necessary
13 emergency care in a foreign country, preventive medical care, and
14 at-home recovery benefit as defined in paragraphs (1), (2), (3),
15 (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8,
16 respectively. The outpatient prescription drug benefit shall not be
17 included in a Medicare supplement contract sold on or after January
18 1, 2006.
19 (12) Standardized Medicare supplement benefit high deductible
20 plan J shall consist of only the following: 100 percent of covered
21 expenses following the payment of the annual high deductible plan
22 J deductible. The covered expenses include the core benefit, plus
23 the Medicare Part A deductible, skilled nursing facility care,
24 Medicare Part B deductible, 100 percent of the Medicare Part B
25 excess charges, extended outpatient prescription drug benefit,
26 medically necessary emergency care in a foreign country,
27 preventive medical care benefit, and at-home recovery benefit as
28 defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of
29 subdivision (c) of Section 1358.8, respectively. The annual high
30 deductible plan J deductible shall consist of out-of-pocket expenses,
31 other than premiums, for services covered by the Medicare
32 supplement plan J policy, and shall be in addition to any other
33 specific benefit deductibles. The annual deductible shall be one
34 thousand five hundred dollars ($1,500) for 1998 and 1999, and
35 shall be based on a calendar year, as adjusted annually thereafter
36 by the secretary to reflect the change in the Consumer Price Index
37 for all urban consumers for the 12-month period ending with
38 August of the preceding year, and rounded to the nearest multiple
39 of ten dollars ($10). The outpatient prescription drug benefit shall

not be included in a Medicare supplement contract sold on or after January 1, 2006.

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

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

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

~~SEC. 7.~~

SEC. 6. Section 1358.91 is added to the Health and Safety Code, to read:

1358.91. 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 plan standards. Benefit plan standards applicable to Medicare supplement contracts issued with an effective date before June 1, 2010, remain subject to the requirements of Section 1358.9.

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

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

1 described in paragraph (3) of subdivision (e), or standardized
2 benefit plan F, as described in paragraph (5) of subdivision (e).
3 (b) No groups, packages or combinations of Medicare
4 supplement benefits other than those listed in this section shall be
5 offered for sale in this state, except as may be permitted in
6 subdivision (f) and by Section 1358.10.
7 (c) Benefit plans shall be uniform in structure, language,
8 designation, and format to the standard benefit plans listed in
9 subdivision (e) and conform to the definitions in Section 1358.4.
10 Each benefit shall be structured in accordance with the format
11 provided in subdivisions (b) and (c) of Section 1358.81; or, in the
12 case of plan K or L, in paragraphs (8) or (9) of subdivision (e) of
13 Section 1358.91 and list the benefits in the order shown in
14 subdivision (e). For purposes of this section, "structure, language,
15 and format" means style, arrangement, and overall content of a
16 benefit.
17 (d) In addition to the benefit plan designations required in
18 subdivision (c), an issuer may use other designations to the extent
19 permitted by law.
20 (e) With respect to the makeup of 2010 standardized benefit
21 plans, the following shall apply:
22 (1) Standardized Medicare supplement benefit plan A shall
23 include only the following: the basic (core) benefits as defined in
24 subdivision (b) of Section 1358.81.
25 (2) Standardized Medicare supplement benefit plan B shall
26 include only the following: the basic (core) benefit as defined in
27 subdivision (b) of Section 1358.81, plus 100 percent of the
28 Medicare Part A deductible as defined in paragraph (1) of
29 subdivision (c) of Section 1358.81.
30 (3) Standardized Medicare supplement benefit plan C shall
31 include only the following: the basic (core) benefit as defined in
32 subdivision (b) of Section 1358.81, plus 100 percent of the
33 Medicare Part A deductible, skilled nursing facility care, 100
34 percent of the Medicare Part B deductible, and medically necessary
35 emergency care in a foreign country, as defined in paragraphs (1),
36 (3), (4), and (6) of subdivision (c) of Section 1358.81, respectively.
37 (4) Standardized Medicare supplement benefit plan D shall
38 include only the following: the basic (core) benefit, as defined in
39 subdivision (b) of Section 1358.81, plus 100 percent of the
40 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.

(5) Standardized Medicare supplement *benefit* 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~~ *benefit high deductible plan F* 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~~ *high deductible plan F* 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 *benefit* plan K shall include only the following:

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

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

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

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

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

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

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

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

1 (I) Coverage of 100 percent of the cost sharing for Medicare
2 Part B preventive services after the enrollee or subscriber pays the
3 Part B deductible.
4 (J) Coverage of 100 percent of all cost sharing under Medicare
5 Parts A and B for the balance of the calendar year after the
6 individual has reached the out-of-pocket limitation on annual
7 expenditures under Medicare Parts A and B of four thousand
8 dollars ($4,000) in 2006, indexed each year by the appropriate
9 inflation adjustment specified by the Secretary of the United States
10 Department of Health and Human Services.
11 (9) Standardized Medicare supplement *benefit* plan L shall
12 include only the following:
13 (A) The benefits described in subparagraphs (A), (B), (C), and
14 (I) of paragraph (8).
15 (B) The benefit described in subparagraphs (D), (E), (F), (G),
16 and (H) of paragraph (8), but substituting 75 percent for 50 percent.
17 (C) The benefit described in subparagraph (J) of paragraph (8),
18 but substituting two thousand dollars ($2,000) for four thousand
19 dollars ($4,000).
20 (10) Standardized Medicare supplement *benefit* plan M shall
21 include only the following: the basic (core) benefit as defined in
22 subdivision (b) of Section 1358.81, plus 50 percent of the Medicare
23 Part A deductible, skilled nursing facility care, and medically
24 necessary emergency care in a foreign country, as defined in
25 paragraphs (2), (3), and (6) of subdivision (c) of Section 1358.81,
26 respectively.
27 (11) Standardized Medicare supplement *benefit* plan N shall
28 include only the following: the basic (core) benefit as defined in
29 subdivision (b) of Section 1358.81, plus 100 percent of the
30 Medicare Part A deductible, skilled nursing facility care, and
31 medically necessary emergency care in a foreign country, as
32 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section
33 1358.81, respectively, with copayments in the following amounts:
34 (A) The lesser of twenty dollars ($20) or the Medicare Part B
35 coinsurance or copayment for each covered health care provider
36 office visit, including visits to medical specialists.
37 (B) The lesser of fifty dollars ($50) or the Medicare Part B
38 coinsurance or copayment for each covered emergency room visit;
39 however, this copayment shall be waived if the enrollee or

1 subscriber is admitted to any hospital and the emergency visit is
2 subsequently covered as a Medicare Part A expense.
3 (f) An issuer may, with the prior approval of the director, offer
4 contracts with new or innovative benefits, in addition to the
5 standardized benefits provided in a contract that otherwise complies
6 with the applicable standards. The new or innovative benefits shall
7 include only benefits that are appropriate to Medicare supplement
8 contracts, are new or innovative, are not otherwise available, and
9 are cost effective. Approval of new or innovative benefits shall
10 not adversely impact the goal of Medicare supplement
11 simplification. New or innovative benefits shall not include an
12 outpatient prescription drug benefit. New or innovative benefits
13 shall not be used to change or reduce benefits, including a change
14 of any cost-sharing provision, in any standardized plan.
15 ~~SEC. 8.~~
16 *SEC. 7.* Section 1358.11 of the Health and Safety Code is
17 amended to read:
18 1358.11. (a) (1) An issuer shall not deny or condition the
19 offering or effectiveness of any Medicare supplement contract
20 available for sale in this state, nor discriminate in the pricing of a
21 contract because of the health status, claims experience, receipt of
22 health care, or medical condition of an applicant in the case of an
23 application for a contract that is submitted prior to or during the
24 six-month period beginning with the first day of the first month
25 in which an individual is both 65 years of age or older and is
26 enrolled for benefits under Medicare Part B. Each Medicare
27 supplement contract currently available from an issuer shall be
28 made available to all applicants who qualify under this subdivision
29 and who are 65 years of age or older.
30 (2) An issuer shall make available Medicare supplement benefit
31 plans A, B, C, and F, if currently available, to an applicant who
32 qualifies under this subdivision who is 64 years of age or younger
33 and who does not have end-stage renal disease. An issuer shall
34 also make available to those applicants, Medicare supplement
35 benefit plan H, I, or J, if currently available, and commencing
36 January 1, 2007, shall make available to them Medicare supplement
37 benefit plan K or L, if currently available. The selection among
38 Medicare supplement benefit plan H, I, or J and the selection
39 between Medicare supplement benefit plan K or L shall be made
40 at the issuer's discretion.

1 (3) This section and Section 1358.12 do not prohibit an issuer
2 in determining subscriber rates from treating applicants who are
3 under 65 years of age and are eligible for Medicare Part B as a
4 separate risk classification.
5 (b) (1) If an applicant qualifies under subdivision (a) and
6 submits an application during the time period referenced in
7 subdivision (a) and, as of the date of application, has had a
8 continuous period of creditable coverage of at least six months,
9 the issuer shall not exclude benefits based on a preexisting
10 condition.
11 (2) If the applicant qualifies under subdivision (a) and submits
12 an application during the time period referenced in subdivision (a)
13 and, as of the date of application, has had a continuous period of
14 creditable coverage that is less than six months, the issuer shall
15 reduce the period of any preexisting condition exclusion by the
16 aggregate of the period of creditable coverage applicable to the
17 applicant as of the enrollment date. The manner of the reduction
18 under this subdivision shall be as specified by the director.
19 (c) Except as provided in subdivision (b) and Section 1358.23,
20 subdivision (a) shall not be construed as preventing the exclusion
21 of benefits under a contract, during the first six months, based on
22 a preexisting condition for which the enrollee received treatment
23 or was otherwise diagnosed during the six months before the
24 coverage became effective.
25 (d) An individual enrolled in Medicare by reason of disability
26 shall be entitled to open enrollment described in this section for
27 six months after the date of his or her enrollment in Medicare Part
28 B, or if notified retroactively of his or her eligibility for Medicare,
29 for six months following notice of eligibility. Sales during the
30 open enrollment period shall not be discouraged by any means,
31 including the altering of the commission structure.
32 (e) (1) An individual enrolled in Medicare Part B is entitled to
33 open enrollment described in this section for six months following:
34 (A) Receipt of a notice of termination or, if no notice is received,
35 the effective date of termination from any employer-sponsored
36 health plan including an employer-sponsored retiree health plan.
37 (B) Receipt of a notice of loss of eligibility due to the divorce
38 or death of a spouse or, if no notice is received, the effective date
39 of loss of eligibility due to the divorce or death of a spouse, from

1 any employer-sponsored health plan including an
2 employer-sponsored retiree health plan.
3 (C) Termination of health care services for a military retiree or
4 the retiree's Medicare eligible spouse or dependent as a result of
5 a military base closure or loss of access to health care services
6 because the base no longer offers services or because the individual
7 relocates.
8 (2) For purposes of this subdivision, "employer-sponsored retiree
9 health plan" includes any coverage for medical expenses, including
10 coverage under the Consolidated Omnibus Budget Reconciliation
11 Act of 1985 (COBRA) and the California Continuation Benefits
12 Replacement Act (Cal-COBRA), that is directly or indirectly
13 sponsored or established by an employer for employees or retirees,
14 their spouses, dependents, or other included covered persons.
15 (f) An individual enrolled in Medicare Part B is entitled to open
16 enrollment described in this section if the individual was covered
17 under a policy, certificate, or contract providing Medicare
18 supplement coverage but that coverage terminated because the
19 individual established residence at a location not served by the
20 issuer.
21 (g) (1) An individual whose coverage was terminated by a
22 Medicare Advantage plan shall be entitled to an additional 60-day
23 open enrollment period to be added on to and run consecutively
24 after any open enrollment period authorized by federal law or
25 regulation, for any and all Medicare supplement coverage available
26 on a guaranteed basis under state and federal law or regulations
27 for persons terminated by their Medicare Advantage plan.
28 (2) Health plans that terminate Medicare enrollees shall notify
29 those enrollees in the termination notice of the additional open
30 enrollment period authorized by this subdivision. Health plan
31 notices shall inform enrollees of the opportunity to secure advice
32 and assistance from the HICAP in their area, along with the
33 toll-free telephone number for HICAP.
34 (h) (1) An individual shall be entitled to an annual open
35 enrollment period lasting 30 days or more, commencing with the
36 individual's birthday, during which time that person may purchase
37 any Medicare supplement coverage that offers benefits equal to
38 or lesser than those provided by the previous coverage. During
39 this open enrollment period, no issuer that falls under this provision
40 shall deny or condition the issuance or effectiveness of Medicare

1 supplement coverage, nor discriminate in the pricing of coverage,
2 because of health status, claims experience, receipt of health care,
3 or medical condition of the individual if, at the time of the open
4 enrollment period, the individual is covered under another
5 Medicare supplement policy, certificate, or contract. An issuer that
6 offers Medicare supplement contracts shall notify an enrollee of
7 his or her rights under this subdivision at least 30 and no more
8 than 60 days before the beginning of the open enrollment period.
9 (2) For purposes of this subdivision, the following provisions
10 shall apply:
11 (A) A 1990 standardized Medicare supplement benefit plan A
12 shall be deemed to offer benefits equal to those provided by a 2010
13 standardized Medicare supplement benefit plan A.
14 (B) A 1990 standardized Medicare supplement benefit plan B
15 shall be deemed to offer benefits equal to those provided by a 2010
16 standardized Medicare supplement benefit plan B.
17 (C) A 1990 standardized Medicare supplement benefit plan C
18 shall be deemed to offer benefits equal to those provided by a 2010
19 standardized Medicare supplement benefit plan C.
20 (D) A 1990 standardized Medicare supplement benefit plan D
21 shall be deemed to offer benefits equal to those provided by a 2010
22 standardized Medicare supplement benefit plan D.
23 (E) A 1990 standardized Medicare supplement benefit plan E
24 shall be deemed to offer benefits equal to those provided by a 2010
25 standardized Medicare benefit plan D.
26 (F) *(i)* A 1990 standardized Medicare supplement benefit plan
27 F shall be deemed to offer benefits equal to those provided by a
28 2010 standardized Medicare benefit plan F.
29 *(ii) A 1990 standardized Medicare supplement benefit high*
30 *deductible plan F shall be deemed to offer benefits equal to those*
31 *provided by a 2010 standardized Medicare supplement benefit*
32 *high deductible plan F.*
33 (G) A 1990 standardized Medicare supplement benefit plan G
34 shall be deemed to offer benefits equal to those provided by a 2010
35 standardized Medicare supplement benefit plan G.
36 (H) A 1990 standardized Medicare supplement benefit plan H
37 shall be deemed to offer benefits equal to those provided by a 2010
38 standardized Medicare supplement benefit plan D.

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

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

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

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

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

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

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

~~SEC. 9.~~

SEC. 8. Section 1358.12 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

1 described above occurs or, commencing January 1, 2007, for one
2 issued by a subsidiary of the parent company of that issuer or by
3 a network that contracts with the parent company of that issuer.
4 (E) The individual demonstrates, in accordance with guidelines
5 established by the secretary, either of the following:
6 (i) The organization offering the plan substantially violated a
7 material provision of the organization's contract under this article
8 in relation to the individual, including the failure to provide on a
9 timely basis medically necessary care for which benefits are
10 available under the plan or the failure to provide the covered care
11 in accordance with applicable quality standards.
12 (ii) The organization, or agent or other entity acting on the
13 organization's behalf, materially misrepresented the plan's
14 provisions in marketing the plan to the individual.
15 (F) The individual meets other exceptional conditions as the
16 secretary may provide.
17 (3) The individual is 65 years of age or older, is enrolled with
18 a Program of All-Inclusive Care for the Elderly (PACE) provider
19 under Section 1894 of the Social Security Act, and circumstances
20 similar to those described in paragraph (2) exist that would permit
21 discontinuance of the individual's enrollment with the provider,
22 if the individual were enrolled in a Medicare Advantage plan.
23 (4) The individual meets both of the following conditions:
24 (A) The individual is enrolled with any of the following:
25 (i) An eligible organization under a contract under Section 1876
26 of the Social Security Act (Medicare cost).
27 (ii) A similar organization operating under demonstration project
28 authority, effective for periods before April 1, 1999.
29 (iii) An organization under an agreement under Section
30 1833(a)(1)(A) of the Social Security Act (health care prepayment
31 plan).
32 (iv) An organization under a Medicare Select policy.
33 (B) The enrollment ceases under the same circumstances that
34 would permit discontinuance of an individual's election of coverage
35 under paragraph (2) or (3).
36 (5) The individual is enrolled under a Medicare supplement
37 contract, and the enrollment ceases because of any of the following
38 circumstances:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b)

is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

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

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

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

SEC. 9. 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.

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

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

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

~~SEC. 11.~~

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

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

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

(b) (1) Except for contract amendments by which the issuer effectuates a request made in writing by the enrollee, exercises a

1 specifically reserved right under a Medicare supplement contract,
2 or is required to reduce or eliminate benefits to avoid duplication
3 of Medicare benefits, all amendments to a Medicare supplement
4 contract after the date of issue or upon reinstatement or renewal
5 that reduce or eliminate benefits or coverage in the contract shall
6 require a signed acceptance by the subscriber. After the date of
7 contract issue, any amendment that increases benefits or coverage
8 with a concomitant increase in prepaid or periodic charges during
9 the contract term shall be agreed to in writing signed by the
10 subscriber, unless the benefits are required by the minimum
11 standards for Medicare supplement contracts, or if the increased
12 benefits or coverage is required by law. If a separate additional
13 charge is made for benefits provided in connection with contract
14 amendments, the charge shall be set forth in the contract.
15 (2) An issuer shall not in any way reduce or eliminate any
16 benefit or coverage under a Medicare supplement contract at any
17 time after the date of entering the contract, including dates of
18 reinstatement or renewal, unless and until the change is voluntarily
19 agreed to in writing signed by the subscriber or enrollee, or is
20 required to reduce or eliminate benefits to avoid duplication of
21 Medicare benefits. The issuer shall not increase benefits or
22 coverage with a concomitant increase in prepaid or periodic charges
23 during the term of the contract unless and until the change is
24 voluntarily agreed to in writing signed by the subscriber or enrollee
25 or unless the increased benefits or coverage is required by law or
26 regulation.
27 (c) Medicare supplement contracts shall not provide for the
28 payment of benefits based on standards described as "usual and
29 customary," "reasonable and customary," or words of similar
30 import.
31 (d) If a Medicare supplement contract contains any limitations
32 with respect to preexisting conditions, those limitations shall appear
33 as a separate paragraph of the contract and be labeled as
34 "Preexisting Condition Limitations."
35 (e) (1) Medicare supplement contracts shall have a notice
36 prominently printed in no less than 10-point uppercase type, on
37 the cover page of the contract or attached thereto stating that the
38 applicant shall have the right to return the contract within 30 days
39 of its receipt via regular mail, and to have any charges refunded
40 in a timely manner if, after examination of the contract, the covered

person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

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

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

(f) (1) Issuers of health care service plan contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis 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 contracts are advertised, solicited, or issued for delivery as Medicare supplement contracts 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 contract is delivered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

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

DISCLOSURES

Use this outline to compare benefits and charges among policies.

[The following additional language shall be included under "DISCLOSURES" for contracts with effective dates on or after June 1, 2010, but shall not appear after June 1, 2011.]

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

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your

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

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

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

(*l*) The director may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage provided to 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:

1
2 "THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT.
3 If you are eligible for Medicare, review the Guide to Health
4 Insurance for People with Medicare available from the company."
5
6 (2) Applications provided to persons eligible for Medicare for
7 the health insurance contracts described in paragraph (1) shall
8 disclose the extent to which the contract duplicates Medicare in a
9 manner required by the director. The disclosure statement shall be
10 provided as a part of, or together with, the application for the
11 contract.
12 (n) A Medicare supplement contract that does not cover
13 custodial care shall, on the cover page of the outline of coverages,
14 contain the following statement in uppercase type: "THIS POLICY
15 DOES NOT COVER CUSTODIAL CARE IN A SKILLED
16 NURSING CARE FACILITY."
17 (o) An issuer shall comply with all notice requirements of the
18 Medicare Prescription Drug, Improvement, and Modernization
19 Act of 2003 (P.L. 108-173).
20 ~~SEC. 12.~~
21 *SEC. 11.* Section 1358.18 of the Health and Safety Code is
22 amended to read:
23 1358.18. In the interest of full and fair disclosure, and to assure
24 the availability of necessary consumer information to potential
25 subscribers or enrollees not possessing a special knowledge of
26 Medicare, health care service plans, or Medicare supplement
27 contracts, an issuer shall comply with the following provisions:
28 (a) Application forms shall include the following questions
29 designed to elicit information as to whether, as of the date of the
30 application, the applicant currently has Medicare supplement,
31 Medicare Advantage, Medi-Cal coverage, or another health
32 insurance policy or certificate or plan contract in force or whether
33 a Medicare supplement contract is intended to replace any other
34 disability policy or certificate, or plan contract, presently in force.
35 A supplementary application or other form to be signed by the
36 applicant and solicitor containing those questions and statements
37 may be used.

“(Statements)

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

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

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

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

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

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

(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 contract or that you had certain rights to buy such a contract, 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 contract

Yes____ No____

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

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and

end dates below. If you are still covered under this plan, leave "END" blank.

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

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

Yes____ No____

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

Yes____ No____

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

Yes____ No____

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

Yes____ No____

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

Yes____ No____

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

Yes____ No____

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

Yes____ No____

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

____

____

____

____

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

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

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

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

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

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

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

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement contract, 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. A direct response issuer shall deliver to the applicant at the time of the issuance of the contract the notice regarding replacement of Medicare supplement coverage.

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

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

(Company name and address)

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate an existing Medicare supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by [Plan Name]. Your contract to be issued by [Plan Name] will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or contract only if, after due consideration, you find that purchase of this Medicare supplement

coverage is a wise decision. STATEMENT TO APPLICANT BY PLAN, SOLICITOR, SOLICITOR FIRM, OR OTHER REPRESENTATIVE:

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

(2) If the issuer of the Medicare supplement contract being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new 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 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 1358.11 or 1358.12, 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~~

(h) An issuer shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of, or open enrollment for, any Medicare supplement coverage pursuant to Section 1358.11 or 1358.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 1358.11 when the applicant is first enrolled in Medicare Part B. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information during a period where guaranteed issue or open enrollment applies, as specified in Section 1358.11 or 1358.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 1358.11 when the applicant is first enrolled in Medicare Part B, and shall inform the applicant of those periods of guaranteed issuance of Medicare supplement coverage. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

~~SEC. 13.~~

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

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

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

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

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

"Notice to buyer: This Medicare supplement contract 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 contract already has health care coverage and the types and amounts of that coverage.

(5) Provide, on the application form for Medicare supplement contracts, 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 Managed Health Care's consumer toll-free telephone number (1-888-HMO-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's Internet Web site (www.dmhc.ca.gov)."

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

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

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

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

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

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

~~SEC. 14.~~

SEC. 13. Section 1358.24 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

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

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

1 (d) Subdivision (c) shall not be construed to preclude an issuer
2 of a Medicare supplement contract from obtaining and using the
3 results of a genetic test in making a determination regarding
4 payment, as defined for the purposes of applying the regulations
5 promulgated under Part C of Title XI and Section 264 of the Health
6 Insurance Portability and Accountability Act of 1996, as may be
7 revised from time to time, and consistent with subdivision (a).
8 (e) For purposes of carrying out subdivision (d), an issuer of a
9 Medicare supplement contract may request only the minimum
10 amount of information necessary to accomplish the intended
11 purpose.
12 (f) An issuer of a Medicare supplement contract shall not
13 request, require, seek, or purchase genetic information for
14 underwriting purposes.
15 (g) An issuer of a Medicare supplement contract shall not
16 request, require, seek, or purchase genetic information with respect
17 to any individual or a family member of that individual prior to
18 the individual's enrollment under the contract in connection with
19 that enrollment.
20 (h) If an issuer of a Medicare supplement contract obtains
21 genetic information incidental to the requesting, requiring, or
22 purchasing of other information concerning any individual or a
23 family member of that individual, the request, requirement, or
24 purchase shall not be considered a violation of subdivision (g) if
25 the request, requirement, or purchase is not in violation of
26 subdivision (f). However, the issuer shall not use any genetic
27 information obtained under this section for any prohibited purpose
28 described in this section or in Sections 1365.5 and 1374.7.
29 (i) For the purposes of this section, the following definitions
30 shall apply:
31 (1) "Issuer of a Medicare supplement contract" includes a
32 third-party administrator, or other person acting for or on behalf
33 of an issuer.
34 (2) "Family member" means, with respect to an individual, any
35 other individual who is a first-degree, second-degree, third-degree,
36 or fourth-degree relative of the individual.
37 (3) "Genetic information" means, with respect to any individual,
38 information about the individual's genetic tests, the genetic tests
39 of family members of the individual, and the manifestation of a
40 disease or disorder in family members of the individual. The term

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.

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

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

~~SEC. 15.~~

SEC. 14. Section 785 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

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

(7) Accidental death insurance.

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

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

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

~~SEC. 16.~~

SEC. 15. Section 10192.4 of the Insurance Code is amended to read:

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

(a) "Applicant" means:

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

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

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

1 (c) "Certificate" means a certificate issued for delivery in this
2 state under a group Medicare supplement policy.
3 (d) "Certificate form" means the form on which the certificate
4 is issued for delivery by the issuer.
5 (e) "Continuous period of creditable coverage" means the period
6 during which an individual was covered by creditable coverage,
7 if during the period of the coverage the individual had no breaks
8 in coverage greater than 63 days.
9 (f) (1) "Creditable coverage" means, with respect to an
10 individual, coverage of the individual provided under any of the
11 following:
12 (A) Any individual or group contract, policy, certificate, or
13 program that is written or administered by a health care service
14 plan, health insurer, fraternal benefits society, self-insured
15 employer plan, or any other entity, in this state or elsewhere, and
16 that arranges or provides medical, hospital, and surgical coverage
17 not designed to supplement other private or governmental plans.
18 The term includes continuation or conversion coverage.
19 (B) Part A or B of Title XVIII of the federal Social Security
20 Act (Medicare).
21 (C) Title XIX of the federal Social Security Act (Medicaid
22 (known as Medi-Cal in California)), other than coverage consisting
23 solely of benefits under Section 1928 of that act.
24 (D) Chapter 55 of Title 10 of the United States Code
25 (CHAMPUS).
26 (E) A medical care program of the Indian Health Service or of
27 a tribal organization.
28 (F) A state health benefits risk pool.
29 (G) A health plan offered under Chapter 89 of Title 5 of the
30 United States Code (Federal Employees Health Benefits Program).
31 (H) A public health plan as defined in federal regulations
32 authorized by Section 2701(c)(1)(I) of the federal Public Health
33 Service Act, as amended by Public Law 104-191, the federal Health
34 Insurance Portability and Accountability Act of 1996.
35 (I) A health benefit plan under Section 5(e) of the federal Peace
36 Corps Act (Section 2504(e) of Title 22 of the United States Code).
37 (J) Any other publicly sponsored program, provided in this state
38 or elsewhere, of medical, hospital, and surgical care.

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

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

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

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

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

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

(A) Limited scope dental or vision benefits.

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

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

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

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

(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) "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.

(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.

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

~~SEC. 17.~~

SEC. 16. 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 limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

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

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

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

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

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

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

~~SEC. 18.~~

SEC. 17. Section 10192.8 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 preexisting conditions, waiting periods, elimination periods, or
2 probationary periods in the new policy or certificate to the extent
3 the time was spent under the original coverage.
4 (F) If a Medicare supplement policy eliminates an outpatient
5 prescription drug benefit as a result of requirements imposed by
6 the Medicare Prescription Drug, Improvement, and Modernization
7 Act of 2003 (P.L. 108-173), the policy as modified as a result of
8 that act shall be deemed to satisfy the guaranteed renewal
9 requirements of this paragraph.
10 (6) Termination of a Medicare supplement policy or certificate
11 shall be without prejudice to any continuous loss that commenced
12 while the policy was in force, but the extension of benefits beyond
13 the period during which the policy was in force may be predicated
14 upon the continuous total disability of the insured, limited to the
15 duration of the policy benefit period, if any, or to payment of the
16 maximum benefits. Receipt of Medicare Part D benefits shall not
17 be considered in determining a continuous loss.
18 (7) (A) (i) A Medicare supplement policy or certificate shall
19 provide that benefits and premiums under the policy or certificate
20 shall be suspended at the request of the policyholder or certificate
21 holder for the period, not to exceed 24 months, in which the
22 policyholder or certificate holder has applied for and is determined
23 to be entitled to Medi-Cal, but only if the policyholder or certificate
24 holder notifies the issuer of the policy or certificate within 90 days
25 after the date the individual becomes entitled to assistance. Upon
26 receipt of timely notice, the insurer shall return directly to the
27 insured that portion of the premium attributable to the period of
28 Medi-Cal eligibility, subject to adjustment for paid claims. If
29 suspension occurs and if the policyholder or certificate holder loses
30 entitlement to Medi-Cal, the policy or certificate shall be
31 automatically reinstituted (effective as of the date of termination
32 of entitlement) as of the termination of entitlement if the
33 policyholder or certificate holder provides notice of loss of
34 entitlement within 90 days after the date of loss and pays the
35 premium attributable to the period, effective as of the date of
36 termination of entitlement, or equivalent coverage shall be provided
37 if the prior form is no longer available.
38 (ii) A Medicare supplement policy or certificate shall provide
39 that benefits and premiums under the policy or certificate shall be
40 suspended at the request of the policyholder or certificate holder

1 for any period that may be provided by federal regulation if the
2 policyholder is entitled to benefits under Section 226(b) of the
3 Social Security Act and is covered under a group health plan, as
4 defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If
5 suspension occurs and the policyholder or certificate holder loses
6 coverage under the group health plan, the policy or certificate shall
7 be automatically reinstituted, effective as of the date of loss of
8 coverage if the policyholder provides notice within 90 days of the
9 date of the loss of coverage.
10 (B) Reinstitution of coverages:
11 (i) Shall not provide for any waiting period with respect to
12 treatment of preexisting conditions.
13 (ii) Shall provide for resumption of coverage that is substantially
14 equivalent to coverage in effect before the date of suspension. If
15 the suspended Medicare supplement policy provided coverage for
16 outpatient prescription drugs, reinstitution of the policy for a
17 Medicare Part D enrollee shall not include coverage for outpatient
18 prescription drugs but shall otherwise provide coverage that is
19 substantially equivalent to the coverage in effect before the date
20 of suspension.
21 (iii) Shall provide for classification of premiums on terms at
22 least as favorable to the policyholder or certificate holder as the
23 premium classification terms that would have applied to the
24 policyholder or certificate holder had the coverage not been
25 suspended.
26 (8) If an issuer makes a written offer to the Medicare supplement
27 policyholders or certificate holders of one or more of its plans, to
28 exchange during a specified period from his or her 1990
29 standardized plan, as described in Section 10192.9, to a 2010
30 standardized plan, as described in Section 10192.91, the offer and
31 subsequent exchange shall comply with the following requirements:
32 (A) An issuer need not provide justification to the commissioner
33 if the insured replaces a 1990 standardized policy or certificate
34 with an issue age rated 2010 standardized policy or certificate at
35 the insured's original issue age and duration. If an insured's policy
36 or certificate to be replaced is priced on an issue age rate schedule
37 at the time of that offer, the rate charged to the insured for the new
38 exchanged policy shall recognize the policy reserve buildup, due
39 to the prefunding inherent in the use of an issue age rate basis, for

1 the benefit of the insured. The method proposed to be used by an
2 issuer shall be filed with the commissioner.
3 (B) The rating class of the new policy or certificate shall be the
4 class closest to the insured's class of the replaced coverage.
5 (C) An issuer shall not apply new preexisting condition
6 limitations or a new incontestability period to the new policy for
7 those benefits contained in the exchanged 1990 standardized policy
8 or certificate of the insured, but may apply preexisting condition
9 limitations of no more than six months to any added benefits
10 contained in the new 2010 standardized policy or certificate not
11 contained in the exchanged policy. This subdivision shall not apply
12 to an applicant who is guaranteed issue under Section 10192.11
13 or 10192.12.
14 (D) The new policy or certificate shall be offered to all
15 policyholders or certificate holders within a given plan, except
16 where the offer or issue would be in violation of state or federal
17 law.
18 (9) A Medicare supplement policy shall not limit coverage
19 exclusively to a single disease or affliction.
20 (b) With respect to the standards for basic (core) benefits for
21 benefit plans A to J, inclusive, every issuer shall make available
22 a policy or certificate including only the following basic "core"
23 package of benefits to each prospective insured. An issuer may
24 make available to prospective insureds any of the other Medicare
25 supplement insurance benefit plans in addition to the basic core
26 package, but not in lieu of it. However, the benefits described in
27 paragraphs (6) and (7) shall not be offered so long as California
28 is required to disallow these benefits for Medicare beneficiaries
29 by the Centers for Medicare and Medicaid Services or other agent
30 of the federal government under Section 1395ss of Title 42 of the
31 United States Code.
32 (1) Coverage of Part A Medicare eligible expenses for
33 hospitalization to the extent not covered by Medicare from the
34 61st day to the 90th day, inclusive, in any Medicare benefit period.
35 (2) Coverage of Part A Medicare eligible expenses incurred for
36 hospitalization to the extent not covered by Medicare for each
37 Medicare lifetime inpatient reserve day used.
38 (3) Upon exhaustion of the Medicare hospital inpatient coverage
39 including the lifetime reserve days, coverage of 100 percent of the
40 Medicare Part A eligible expenses for hospitalization paid at the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) With respect to the following, reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, up to a maximum of one hundred

twenty dollars ($120) annually under this benefit, however, this benefit shall not include payment for any procedure covered by Medicare:

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

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

(i) Fecal occult blood test.

(ii) Mammogram.

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

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

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

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

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

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

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

1 (B) With respect to coverage requirements and limitations, the
2 following shall apply:
3 (i) At-home recovery services provided shall be primarily
4 services that assist in activities of daily living.
5 (ii) The insured's attending physician shall certify that the
6 specific type and frequency of at-home recovery services are
7 necessary because of a condition for which a home care plan of
8 treatment was approved by Medicare.
9 (iii) Coverage is limited to the following:
10 (I) No more than the number and type of at-home recovery visits
11 certified as necessary by the insured's attending physician. The
12 total number of at-home recovery visits shall not exceed the number
13 of Medicare-approved home health care visits under a
14 Medicare-approved home care plan of treatment.
15 (II) The actual charges for each visit up to a maximum
16 reimbursement of forty dollars ($40) per visit.
17 (III) One thousand six hundred dollars ($1,600) per calendar
18 year.
19 (IV) Seven visits in any one week.
20 (V) Care furnished on a visiting basis in the insured's home.
21 (VI) Services provided by a care provider as defined in
22 subparagraph (A).
23 (VII) At-home recovery visits while the insured is covered under
24 the policy or certificate and not otherwise excluded.
25 (VIII) At-home recovery visits received during the period the
26 insured is receiving Medicare-approved home care services or no
27 more than eight weeks after the service date of the last
28 Medicare-approved home health care visit.
29 (C) Coverage is excluded for the following:
30 (i) Home care visits paid for by Medicare or other government
31 programs.
32 (ii) Care provided by family members, unpaid volunteers, or
33 providers who are not care providers.
34 (d) The standardized Medicare supplement benefit plan "K"
35 shall consist of the following benefits:
36 (1) Coverage of 100 percent of the Medicare Part A hospital
37 coinsurance amount for each day used from the 61st to the 90th
38 day, inclusive, in any Medicare benefit period.
39 (2) Coverage of 100 percent of the Medicare Part A hospital
40 coinsurance amount for each Medicare lifetime inpatient reserve

day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.

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

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

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

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

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

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

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

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual

1 expenditures under Medicare Parts A and B of four thousand
2 dollars ($4,000) in 2006, indexed each year by the appropriate
3 inflation adjustment specified by the secretary.
4 (e) The standardized Medicare supplement benefit plan “L”
5 shall consist of the following benefits:
6 (1) The benefits described in paragraphs (1), (2), (3), and (9) of
7 subdivision (d).
8 (2) With respect to the Medicare Part A deductible, coverage
9 for 75 percent of the Medicare Part A inpatient hospital deductible
10 amount per benefit period until the out-of-pocket limitation
11 described in paragraph (8) is met.
12 (3) With respect to skilled nursing facility care, coverage for
13 75 percent of the coinsurance amount for each day used from the
14 21st day to the 100th day, inclusive, in a Medicare benefit period
15 for posthospital skilled nursing facility care eligible under Medicare
16 Part A until the out-of-pocket limitation described in paragraph
17 (8) is met.
18 (4) With respect to hospice care, coverage for 75 percent of cost
19 sharing for all Medicare Part A eligible expenses and respite care
20 until the out-of-pocket limitation described in paragraph (8) is met.
21 (5) Coverage for 75 percent, under Medicare Part A or B, of
22 the reasonable cost of the first three pints of blood or equivalent
23 quantities of packed red blood cells, as defined under federal
24 regulations, unless replaced in accordance with federal regulations,
25 until the out-of-pocket limitation described in paragraph (8) is met.
26 (6) Except for coverage provided in paragraph (7), coverage for
27 75 percent of the cost sharing otherwise applicable under Medicare
28 Part B after the policyholder pays the Part B deductible until the
29 out-of-pocket limitation described in paragraph (8) is met.
30 (7) Coverage for 100 percent of the cost sharing for Medicare
31 Part B preventive services after the policyholder pays the Part B
32 deductible.
33 (8) Coverage of 100 percent of the cost sharing for Medicare
34 Parts A and B for the balance of the calendar year after the
35 individual has reached the out-of-pocket limitation on annual
36 expenditures under Medicare Parts A and B of two thousand dollars
37 ($2,000) in 2006, indexed each year by the appropriate inflation
38 adjustment specified by the secretary.
39 (f) An issuer shall prominently indicate through text edits, or
40 by other means acceptable to the commissioner, an amendment

made to a Medicare supplement policy form that the department previously approved on the basis that the amendment is consistent with this section. The department may, in its discretion, restrict its review to amendments made to Medicare supplement policy forms that have not previously been found consistent with this section in order to facilitate the availability of amended policy forms that are consistent with the federal Medicare Modernization Act. The department shall not restrict its review if the amendment makes additional changes to the Medicare supplement policy form.

~~SEC. 19.~~

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

10192.81. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state 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 standards. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale with an effective date on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date prior to June 1, 2010, remain subject to the requirements of Section 10192.8.

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

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

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

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under

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

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

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

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

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

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

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

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

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

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

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

(E) (i) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result

1 in any exclusion for preexisting conditions that would have been
2 covered under the group policy being replaced.
3 (ii) If a Medicare supplement policy or certificate replaces
4 another Medicare supplement policy or certificate that has been
5 in force for six months or more, the replacing issuer shall not
6 impose an exclusion or limitation based on a preexisting condition.
7 If the original coverage has been in force for less than six months,
8 the replacing issuer shall waive any time period applicable to
9 preexisting conditions, waiting periods, elimination periods, or
10 probationary periods in the new policy or certificate to the extent
11 the time was spent under the original coverage.
12 (6) Termination of a Medicare supplement policy or certificate
13 shall be without prejudice to any continuous loss that commenced
14 while the policy was in force, but the extension of benefits beyond
15 the period during which the policy was in force may be predicated
16 upon the continuous total disability of the insured, limited to the
17 duration of the policy benefit period, if any, or payment of the
18 maximum benefits. Receipt of Medicare Part D benefits shall not
19 be considered in determining a continuous loss.
20 (7) (A) (i) A Medicare supplement policy or certificate shall
21 provide that benefits and premiums under the policy or certificate
22 shall be suspended at the request of the policyholder or certificate
23 holder for the period, not to exceed 24 months, in which the
24 policyholder or certificate holder has applied for and is determined
25 to be entitled to medical assistance under Medi-Cal, but only if
26 the policyholder or certificate holder notifies the issuer of the
27 policy or certificate within 90 days after the date the individual
28 becomes entitled to assistance. Upon receipt of timely notice, the
29 insurer shall return directly to the insured that portion of the
30 premium attributable to the period of Medi-Cal eligibility, subject
31 to adjustment for paid claims.
32 (ii) If suspension occurs and if the policyholder or certificate
33 holder loses entitlement to medical assistance under Medi-Cal, the
34 policy or certificate shall be automatically reinstituted (effective
35 as of the date of termination of entitlement) as of the termination
36 of entitlement if the policyholder or certificate holder provides
37 notice of loss of entitlement within 90 days after the date of loss
38 and pays the premium attributable to the period, effective as of the
39 date of termination of entitlement or equivalent coverage shall be
40 provided if the prior form is no longer available.

1 (iii) Each Medicare supplement policy shall provide that benefits
2 and premiums under the policy shall be suspended (for any period
3 that may be provided by federal regulation) at the request of the
4 policyholder if the policyholder is entitled to benefits under Section
5 226(b) of the Social Security Act and is covered under a group
6 health plan (as defined in Section 1862(b)(1)(A)(v) of the Social
7 Security Act). If suspension occurs and if the policyholder or
8 certificate holder loses coverage under the group health plan, the
9 policy shall be automatically reinstituted (effective as of the date
10 of loss of coverage) if the policyholder provides notice of loss of
11 coverage within 90 days after the date of the loss and pays the
12 applicable premium.
13 (B) Reinstitution of coverages shall comply with all of the
14 following requirements:
15 (i) Not provide for any waiting period with respect to treatment
16 of preexisting conditions.
17 (ii) Provide for resumption of coverage that is substantially
18 equivalent to coverage in effect before the date of suspension.
19 (iii) Provide for classification of premiums on terms at least as
20 favorable to the policyholder or certificate holder as the premium
21 classification terms that would have applied to the policyholder
22 or certificate holder had the coverage not been suspended.
23 (8) A Medicare supplement policy shall not limit coverage
24 exclusively to a single disease or affliction.
25 (9) A Medicare supplement policy shall provide an examination
26 period of 30 days after the receipt of the policy by the applicant
27 for purposes of review, during which time the applicant may return
28 the policy as described in subdivision (e) of Section 10192.17.
29 (b) With respect to the standards for basic (core) benefits for
30 benefit plans A, B, C, D, F, ~~F with high deductible~~ *high deductible*
31 *F*, G, M, and N, every issuer of Medicare supplement insurance
32 benefit plans shall make available a policy or certificate including
33 only the following basic "core" package of benefits to each
34 prospective insured. An issuer may make available to prospective
35 insureds any of the other Medicare Supplement Insurance Benefit
36 Plans in addition to the basic (core) package, but not in lieu of it.
37 However, the benefits described in paragraphs (6) and (7) shall
38 not be offered so long as California is required to disallow these
39 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 through the 90th day, inclusive, in any Medicare benefit period.

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

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

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

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

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

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

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

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

1 (1) With respect to the Medicare Part A deductible, coverage
2 for 100 percent of the Medicare Part A inpatient hospital deductible
3 amount per benefit period.
4 (2) With respect to the Medicare Part A deductible, coverage
5 for 50 percent of the Medicare Part A inpatient hospital deductible
6 amount per benefit period.
7 (3) With respect to skilled nursing facility care, coverage for
8 the actual billed charges up to the coinsurance amount from the
9 21st day through the 100th day in a Medicare benefit period for
10 posthospital skilled nursing facility care eligible under Medicare
11 Part A.
12 (4) With respect to the Medicare Part B deductible, coverage
13 for 100 percent of the Medicare Part B deductible amount per
14 calendar year regardless of hospital confinement.
15 (5) With respect to 100 percent of the Medicare Part B excess
16 charges, coverage for all of the difference between the actual
17 Medicare Part B charges as billed, not to exceed any charge
18 limitation established by the Medicare program or state law, and
19 the Medicare-approved Part B charge.
20 (6) With respect to medically necessary emergency care in a
21 foreign country, coverage to the extent not covered by Medicare
22 for 80 percent of the billed charges for Medicare-eligible expenses
23 for medically necessary emergency hospital, physician, and medical
24 care received in a foreign country, which care would have been
25 covered by Medicare if provided in the United States and which
26 care began during the first 60 consecutive days of each trip outside
27 the United States, subject to a calendar year deductible of $250,
28 and a lifetime maximum benefit of $50,000. For purposes of this
29 benefit, "emergency care" shall mean care needed immediately
30 because of an injury or an illness of sudden and unexpected onset.
31 ~~SEC. 20.~~
32 *SEC. 19.* Section 10192.9 of the Insurance Code is amended
33 to read:
34 10192.9. The following standards are applicable to all Medicare
35 supplement policies or certificates delivered or issued for delivery
36 in this state on or after July 1, 1992, and with an effective date
37 prior to June 1, 2010.
38 (a) An issuer shall make available to each prospective
39 policyholder and certificate holder a policy form or certificate form

1 containing only the basic (core) benefits, as defined in subdivision
2 (b) of Section 10192.8.
3 (b) No groups, packages, or combinations of Medicare
4 supplement benefits other than those listed in this section shall be
5 offered for sale in this state, except as may be permitted by
6 subdivision (f) and by Section 10192.10.
7 (c) Benefit plans shall be uniform in structure, language,
8 designation and format to the standard benefit plans A to J,
9 inclusive, listed in subdivision (e), and shall conform to the
10 definitions in Section 10192.4. Each benefit shall be structured in
11 accordance with the format provided in subdivisions (b), (c), (d),
12 and (e) of Section 10192.8 and list the benefits in the order listed
13 in subdivision (e). For purposes of this section, "structure,
14 language, and format" means style, arrangement, and overall
15 content of a benefit.
16 (d) An issuer may use, in addition to the benefit plan
17 designations required in subdivision (c), other designations to the
18 extent permitted by law.
19 (e) With respect to the makeup of benefit plans, the following
20 shall apply:
21 (1) Standardized Medicare supplement benefit plan A shall be
22 limited to the basic (core) benefit common to all benefit plans, as
23 defined in subdivision (b) of Section 10192.8.
24 (2) Standardized Medicare supplement benefit plan B shall
25 include only the following: the core benefit, plus the Medicare
26 Part A deductible as defined in paragraph (1) of subdivision (c) of
27 Section 10192.8.
28 (3) Standardized Medicare supplement benefit plan C shall
29 include only the following: the core benefit, plus the Medicare
30 Part A deductible, skilled nursing facility care, Medicare Part B
31 deductible, and medically necessary emergency care in a foreign
32 country as defined in paragraphs (1), (2), (3), and (8) of subdivision
33 (c) of Section 10192.8, respectively.
34 (4) Standardized Medicare supplement benefit plan D shall
35 include only the following: the core benefit, plus the Medicare
36 Part A deductible, skilled nursing facility care, medically necessary
37 emergency care in a foreign country, and the at-home recovery
38 benefit as defined in paragraphs (1), (2), (8), and (10) of
39 subdivision (c) of Section 10192.8, respectively.

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

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

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

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

1 (9) Standardized Medicare supplement benefit plan H shall
2 consist of only the following: the core benefit, plus the Medicare
3 Part A deductible, skilled nursing facility care, basic outpatient
4 prescription drug benefit, and medically necessary emergency care
5 in a foreign country as defined in paragraphs (1), (2), (6), and (8)
6 of subdivision (c) of Section 10192.8, respectively. The outpatient
7 prescription drug benefit shall not be included in a Medicare
8 supplement policy sold on or after January 1, 2006.
9 (10) Standardized Medicare supplement benefit plan I shall
10 consist of only the following: the core benefit, plus the Medicare
11 Part A deductible, skilled nursing facility care, 100 percent of the
12 Medicare Part B excess charges, basic outpatient prescription drug
13 benefit, medically necessary emergency care in a foreign country,
14 and at-home recovery benefit as defined in paragraphs (1), (2),
15 (5), (6), (8), and (10) of subdivision (c) of Section 10192.8,
16 respectively. The outpatient prescription drug benefit shall not be
17 included in a Medicare supplement policy sold on or after January
18 1, 2006.
19 (11) Standardized Medicare supplement benefit plan J shall
20 consist of only the following: the core benefit, plus the Medicare
21 Part A deductible, skilled nursing facility care, Medicare Part B
22 deductible, 100 percent of the Medicare Part B excess charges,
23 extended outpatient prescription drug benefit, medically necessary
24 emergency care in a foreign country, preventive medical care, and
25 at-home recovery benefit as defined in paragraphs (1), (2), (3),
26 (5), (7), (8), (9), 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 (12) Standardized Medicare supplement benefit high deductible
31 plan J shall consist of only the following: 100 percent of covered
32 expenses following the payment of the annual high deductible plan
33 J deductible. The covered expenses include the core benefit, plus
34 the Medicare Part A deductible, skilled nursing facility care,
35 Medicare Part B deductible, 100 percent of the Medicare Part B
36 excess charges, extended outpatient prescription drug benefit,
37 medically necessary emergency care in a foreign country,
38 preventive medical care benefit, and at-home recovery benefit as
39 defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of
40 subdivision (c) of Section 10192.8, respectively. The annual high

deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

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

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

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

~~SEC. 21.~~

SEC. 20. 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

1 effective date before June 1, 2010, remain subject to the
2 requirements of Section 10192.9.
3 (a) (1) An issuer shall make available to each prospective
4 policyholder and certificate holder a policy form or certificate form
5 containing only the basic (core) benefits, as defined in subdivision
6 (b) of Section 10192.81.
7 (2) If an issuer makes available any of the additional benefits
8 described in subdivision (c) of Section 10192.81, or offers
9 standardized benefit plans K or L, as described in paragraphs (8)
10 and (9) of subdivision (e), then the issuer shall make available to
11 each prospective policyholder and certificate holder, in addition
12 to a policy form or certificate form with only the basic core benefits
13 as described in paragraph (1), a policy form or certificate form
14 containing either standardized benefit plan C, as described in
15 paragraph (3) of subdivision (e), or standardized benefit plan F,
16 as described in paragraph (5) of subdivision (e).
17 (b) No groups, packages, or combinations of Medicare
18 supplement benefits other than those listed in this section shall be
19 offered for sale in this state, except as may be permitted in
20 subdivision (f) and by Section 10192.10.
21 (c) Benefit plans shall be uniform in structure, language,
22 designation, and format to the standard benefit plans listed in
23 subdivision (e) and conform to the definitions in Section 10192.4.
24 Each benefit shall be structured in accordance with the format
25 provided in subdivisions (b) and (c) of Section 10192.81; or, in
26 the case of plan K or L, in paragraph (8) or (9) of subdivision (e)
27 and list the benefits in the order shown in subdivision (e). For
28 purposes of this section, “structure, language, and format” means
29 style, arrangement, and overall content of a benefit.
30 (d) In addition to the benefit plan designations required in
31 subdivision (c), an issuer may use other designations to the extent
32 permitted by law.
33 (e) With respect to the makeup of 2010 standardized benefit
34 plans, the following shall apply:
35 (1) Standardized Medicare supplement benefit plan A shall
36 include only the basic (core) benefits as defined in subdivision (b)
37 of Section 10192.81.
38 (2) Standardized Medicare supplement benefit plan B shall
39 include only the following: the basic (core) benefit as defined in
40 subdivision (b) of Section 10192.81, plus 100 percent of the

Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 10192.81.

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

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

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

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

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

(B) The annual deductible in ~~plan F with high deductible~~ *high deductible plan F* shall consist of out-of-pocket expenses, other

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

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

(8) Standardized Medicare supplement *benefit* plan K shall include only the following:

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

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

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

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

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

1 (F) Coverage for 50 percent of cost sharing for all Part A
2 Medicare eligible expenses and respite care until the out-of-pocket
3 limitation is met as described in subparagraph (J).
4 (G) Coverage for 50 percent, under Medicare Part A or B, of
5 the reasonable cost of the first three pints of blood, or equivalent
6 quantities of packed red blood cells, as defined under federal
7 regulations, unless replaced in accordance with federal regulations
8 until the out-of-pocket limitation is met as described in
9 subparagraph (J).
10 (H) Except for coverage provided in subparagraph (I), coverage
11 for 50 percent of the cost sharing otherwise applicable under
12 Medicare Part B after the policyholder pays the Part B deductible
13 until the out-of-pocket limitation is met as described in
14 subparagraph (J).
15 (I) Coverage of 100 percent of the cost sharing for Medicare
16 Part B preventive services after the policyholder pays the Part B
17 deductible.
18 (J) Coverage of 100 percent of all cost sharing under Medicare
19 Parts A and B for the balance of the calendar year after the
20 individual has reached the out-of-pocket limitation on annual
21 expenditures under Medicare Parts A and B of four thousand
22 dollars ($4,000) in 2006, indexed each year by the appropriate
23 inflation adjustment specified by the Secretary of the United States
24 Department of Health and Human Services.
25 (9) Standardized Medicare supplement *benefit* plan L shall
26 include only the following:
27 (A) The benefits described in subparagraphs (A), (B), (C), and
28 (I) of paragraph (8).
29 (B) The benefit described in subparagraphs (D), (E), (F), (G),
30 and (H) of paragraph (8), but substituting 75 percent for 50 percent.
31 (C) The benefit described in subparagraph (J) of paragraph (8),
32 but substituting two thousand dollars ($2,000) for four thousand
33 dollars ($4,000).
34 (10) Standardized Medicare supplement *benefit* plan M shall
35 include only the following: the basic (core) benefit as defined in
36 subdivision (b) of Section 10192.81, plus 50 percent of the
37 Medicare Part A deductible, skilled nursing facility care, and
38 medically necessary emergency care in a foreign country, as
39 defined in paragraphs (2), (3), and (6) of subdivision (c) of Section
40 10192.81, respectively.

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

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

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

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

~~SEC. 22.~~

SEC. 21. Section 10192.11 of the Insurance Code is amended to read:

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

Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

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

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

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

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

(c) Except as provided in subdivision (b) and Section 10192.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate

holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

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

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

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

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

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

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, 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.

~~(1)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Commencing January 1, 2007, an individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for

1 benefits, including benefits with a share of cost, under the Medi-Cal
2 program because of an increase in the individual's income or assets.
3 ~~SEC. 23.~~
4 *SEC. 22.* Section 10192.12 of the Insurance Code is amended
5 to read:
6 10192.12. (a) (1) With respect to the guaranteed issue of a
7 Medicare supplement policy, eligible persons are those individuals
8 described in subdivision (b) who seek to enroll under the policy
9 during the period specified in subdivision (c), and who submit
10 evidence of the date of termination or disenrollment or enrollment
11 in Medicare Part D with the application for a Medicare supplement
12 policy.
13 (2) With respect to eligible persons, an issuer shall not take any
14 of the following actions:
15 (A) Deny or condition the issuance or effectiveness of a
16 Medicare supplement policy described in subdivision (e) that is
17 offered and is available for issuance to new enrollees by the issuer.
18 (B) Discriminate in the pricing of that Medicare supplement
19 policy because of health status, claims experience, receipt of health
20 care, or medical condition.
21 (C) Impose an exclusion of benefits based on a preexisting
22 condition under that Medicare supplement policy.
23 (b) An eligible person is an individual described in any of the
24 following paragraphs:
25 (1) The individual is enrolled under an employee welfare benefit
26 plan that provides health benefits that supplement the benefits
27 under Medicare, the plan either terminates or ceases to provide all
28 of those supplemental health benefits to the individual, and the
29 employer no longer provides the individual with insurance that
30 covers all of the payment for the 20-percent coinsurance.
31 (2) The individual is enrolled with a Medicare Advantage
32 organization under a Medicare Advantage plan under Medicare
33 Part C, and any of the following circumstances apply:
34 (A) The certification of the organization or plan has been
35 terminated.
36 (B) The organization has terminated or otherwise discontinued
37 providing the plan in the area in which the individual resides.
38 (C) The individual is no longer eligible to elect the plan because
39 of a change in the individual's place of residence or other change
40 in circumstances specified by the secretary. Those changes in

1 circumstances shall not include termination of the individual's
2 enrollment on the basis described in Section 1851(g)(3)(B) of the
3 federal Social Security Act where the individual has not paid
4 premiums on a timely basis or has engaged in disruptive behavior
5 as specified in standards under Section 1856, or the plan is
6 terminated for all individuals within a residence area.
7 (D) The Medicare Advantage plan in which the individual is
8 enrolled reduces any of its benefits or increases the amount of cost
9 sharing or discontinues for other than good cause relating to quality
10 of care, its relationship or contract under the plan with a provider
11 who is currently furnishing services to the individual. An individual
12 shall be eligible under this subparagraph for a Medicare supplement
13 policy issued by the same issuer through which the individual was
14 enrolled at the time the reduction, increase, or discontinuance
15 described above occurs or, commencing January 1, 2007, for one
16 issued by a subsidiary of the parent company of that issuer or by
17 a network that contracts with the parent company of that issuer.
18 (E) The individual demonstrates, in accordance with guidelines
19 established by the secretary, either of the following:
20 (i) The organization offering the plan substantially violated a
21 material provision of the organization's contract under this article
22 in relation to the individual, including the failure to provide on a
23 timely basis medically necessary care for which benefits are
24 available under the plan or the failure to provide the covered care
25 in accordance with applicable quality standards.
26 (ii) The organization, or agent or other entity acting on the
27 organization's behalf, materially misrepresented the plan's
28 provisions in marketing the plan to the individual.
29 (F) The individual meets other exceptional conditions as the
30 secretary may provide.
31 (3) The individual is 65 years of age or older, is enrolled with
32 a Program of All-Inclusive Care for the Elderly (PACE) provider
33 under Section 1894 of the Social Security Act, and circumstances
34 similar to those described in paragraph (2) exist that would permit
35 discontinuance of the individual's enrollment with the provider,
36 if the individual were enrolled in a Medicare Advantage plan.
37 (4) The individual meets both of the following conditions:
38 (A) The individual is enrolled with any of the following:
39 (i) An eligible organization under a contract under Section 1876
40 of the Social Security Act (Medicare cost).

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

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

(iv) An organization under a Medicare Select policy.

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

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

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

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

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

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

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

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

(7) The individual upon first becoming eligible for benefits under Medicare Part A at 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from

the plan or program not later than 12 months after the effective date of enrollment.

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

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

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

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

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

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

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

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

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

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of

1 the Social Security Act from the Medicare supplement issuer during
2 the 60-day period immediately preceding the initial enrollment
3 period for Medicare Part D and ends on the date that is 63 days
4 after the effective date of the individual's coverage under Medicare
5 Part D.
6 (6) In the case of an individual described in subdivision (b) who
7 is not included in this subdivision, the guaranteed issue period
8 begins on the effective date of disenrollment and ends on the date
9 that is 63 days after the effective date of disenrollment.
10 (d) (1) In the case of an individual described in paragraph (6)
11 of subdivision (b), or deemed to be so described pursuant to this
12 paragraph, whose enrollment with an organization or provider
13 described in subparagraph (A) of paragraph (6) of subdivision (b)
14 is involuntarily terminated within the first 12 months of enrollment
15 and who, without an intervening enrollment, enrolls with another
16 such organization or provider, the subsequent enrollment shall be
17 deemed to be an initial enrollment described in paragraph (6) of
18 subdivision (b).
19 (2) In the case of an individual described in paragraph (7) of
20 subdivision (b), or deemed to be so described pursuant to this
21 paragraph, whose enrollment with a plan or in a program described
22 in paragraph (7) of subdivision (b) is involuntarily terminated
23 within the first 12 months of enrollment and who, without an
24 intervening enrollment, enrolls in another such plan or program,
25 the subsequent enrollment shall be deemed to be an initial
26 enrollment described in paragraph (7) of subdivision (b).
27 (3) For purposes of paragraphs (6) and (7) of subdivision (b),
28 an enrollment of an individual with an organization or provider
29 described in subparagraph (A) of paragraph (6) of subdivision (b),
30 or with a plan or in a program described in paragraph (7) of
31 subdivision (b) shall not be deemed to be an initial enrollment
32 under this paragraph after the two-year period beginning on the
33 date on which the individual first enrolled with such an
34 organization, provider, plan, or program.
35 (e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision
36 (b), an eligible individual is entitled to a Medicare supplement
37 policy that has a benefit package classified as Plan A, B, C, F
38 (including a high deductible Plan F), K, or L offered by any issuer.
39 (2) (A) Under paragraph (6) of subdivision (b), an eligible
40 individual is entitled to the same Medicare supplement policy in

1 which he or she was most recently enrolled, if available from the
2 same issuer. If that policy is not available, the eligible individual
3 is entitled to a Medicare supplement policy that has a benefit
4 package classified as Plan A, B, C, F (including a high deductible
5 Plan F), K, or L offered by any issuer.
6 (B) On and after January 1, 2006, an eligible individual
7 described in this paragraph who was most recently enrolled in a
8 Medicare supplement policy with an outpatient prescription drug
9 benefit, is entitled to a Medicare supplement policy that is available
10 from the same issuer but without an outpatient prescription drug
11 benefit or, at the election of the individual, has a benefit package
12 classified as a Plan A, B, C, F (including high deductible Plan F),
13 K, or L that is offered by any issuer.
14 (3) Under paragraph (7) of subdivision (b), an eligible individual
15 is entitled to any Medicare supplement policy offered by any issuer.
16 (4) Under paragraph (8) of subdivision (b), an eligible individual
17 is entitled to a Medicare supplement policy that has a benefit
18 package classified as Plan A, B, C, F (including a high deductible
19 Plan F), K, or L and that is offered and is available for issuance to
20 a new enrollee by the same issuer that issued the individual's
21 Medicare supplement policy with outpatient prescription drug
22 coverage.
23 (f) (1) At the time of an event described in subdivision (b) by
24 which an individual loses coverage or benefits due to the
25 termination of a contract or agreement, policy, or plan, the
26 organization that terminates the contract or agreement, the issuer
27 terminating the policy, or the administrator of the plan being
28 terminated, respectively, shall notify the individual of his or her
29 rights under this section and of the obligations of issuers of
30 Medicare supplement policies under subdivision (a). The notice
31 shall be communicated contemporaneously with the notification
32 of termination.
33 (2) At the time of an event described in subdivision (b) by which
34 an individual ceases enrollment under a contract or agreement,
35 policy, or plan, the organization that offers the contract or
36 agreement, regardless of the basis for the cessation of enrollment,
37 the issuer offering the policy, or the administrator of the plan,
38 respectively, shall notify the individual of his or her rights under
39 this section, and of the obligations of issuers of Medicare
40 supplement policies under subdivision (a). The notice shall be

1 communicated within 10 working days of the date the issuer
2 received notification of disenrollment.
3 (g) An issuer shall refund any unearned premium that an insured
4 paid in advance and shall terminate coverage upon the request of
5 an insured.
6 ~~SEC. 24.~~
7 *SEC. 23.* Section 10192.13 of the Insurance Code is amended
8 to read:
9 10192.13. (a) An issuer shall comply with Section 1882(c)(3)
10 of the federal Social Security Act (as enacted by Section
11 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
12 of 1987 (OBRA), Public Law 100-203) by doing all of the
13 following and by certifying compliance on the Medicare
14 supplement insurance experience reporting form:
15 (1) Accepting a notice from a Medicare Administrative
16 Contractor, formerly known as a fiscal intermediary or carrier, on
17 dually assigned claims submitted by participating physicians and
18 suppliers as a claim for benefits in place of any other claim form
19 otherwise required and making a payment determination on the
20 basis of the information contained in that notice.
21 (2) Notifying the participating physician or supplier and the
22 beneficiary of the payment determination.
23 (3) Paying the participating physician or supplier directly.
24 (4) Furnishing, at the time of enrollment, each enrollee with a
25 card listing the policy name, number, and a central mailing address
26 to which notices from Medicare Administrative Contractors may
27 be sent.
28 (5) Paying user fees for claim notices that are transmitted
29 electronically or otherwise.
30 (6) Providing to the secretary, at least annually, a central mailing
31 address to which all claims may be sent by Medicare
32 Administrative Contractors.
33 (7) File, by June 30 of each year, with the commissioner a list
34 of its Medicare supplement policies and certificates offered or
35 issued or in force in California as of the end of the previous year.
36 (A) The list shall identify the issuer by name and address, shall
37 identify each type of form it offers by name and form number, and
38 shall differentiate between forms approved in the previous calendar
39 year and those approved before the previous calendar year.
40 (B) The list shall identify all of the following:

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

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

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

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

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

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

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

~~SEC. 25.~~

SEC. 24. Section 10192.17 of the Insurance Code is amended to read:

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

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in

1 writing signed by the insured, unless the benefits are required by
2 the minimum standards for Medicare supplement policies, or if
3 the increased benefits or coverage is required by law. If a separate
4 additional premium is charged for benefits provided in connection
5 with riders or endorsements, the premium charge shall be set forth
6 in the policy.
7 (c) Medicare supplement policies or certificates shall not provide
8 for the payment of benefits based on standards described as "usual
9 and customary," "reasonable and customary," or words of similar
10 import.
11 (d) If a Medicare supplement policy or certificate contains any
12 limitations with respect to preexisting conditions, those limitations
13 shall appear as a separate paragraph of the policy and be labeled
14 as "Preexisting Condition Limitations."
15 (e) (1) Medicare supplement policies and certificates shall have
16 a notice prominently printed on the first page of the policy or
17 certificate, and of the outline of coverage, or attached thereto, in
18 no less than 10-point uppercase type, stating in substance that the
19 policyholder or certificate holder shall have the right to return the
20 policy or certificate, via regular mail, within 30 days of receiving
21 it, and to have the full premium refunded if, after examination of
22 the policy or certificate, the insured person is not satisfied for any
23 reason. The return shall void the contract from the beginning, and
24 the parties shall be in the same position as if no contract had been
25 issued.
26 (2) For purposes of this section, a timely manner shall be no
27 later than 30 days after the issuer receives the returned contract.
28 (3) If the issuer fails to refund all prepaid or periodic charges
29 paid in a timely manner, then the applicant shall receive interest
30 on the paid charges at the legal rate of interest on judgments as
31 provided in Section 685.010 of the Code of Civil Procedure. The
32 interest shall be paid from the date the issuer received the returned
33 contract.
34 (f) (1) Issuers of health insurance policies, certificates, or
35 contracts that provide hospital or medical expense coverage on an
36 expense incurred or indemnity basis, other than incidentally, to
37 persons eligible for Medicare shall provide to those applicants a
38 Guide to Health Insurance for People with Medicare in the form
39 developed jointly by the National Association of Insurance
40 Commissioners and the Centers for Medicare and Medicaid

Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the policy is delivered.

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

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

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

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

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

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

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

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

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All Medicare supplement plans authorized by federal law shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

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

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

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

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

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

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

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

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

(3) The outline of coverage shall be in the language and format prescribed in this subdivision in no less than 12-point type, and shall include the following items in the order prescribed below.

Titles, as set forth below in paragraphs (B) to (H), inclusive, shall be capitalized, centered, and printed in boldface type.

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

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

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

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

The BASIC BENEFITS included in ALL plans are:

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

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

Blood: First three pints of blood each year.

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

Cervical cancer test: One annual screening."

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

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

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

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

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

The BASIC BENEFITS included in ALL plans are:

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

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

Cervical cancer test: One annual screening."

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

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

raise your premium if we raise the premium for all policies like yours in California."

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

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

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

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

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

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

(H) [For policies that are not guaranteed issue] COMPLETE ANSWERS ARE IMPORTANT. The text shall read: "When you fill out the application for a new policy, be sure to answer truthfully and completely all questions about your medical and health history.

The company may have the right to cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

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

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

~~SEC. 26.~~

SEC. 25. Section 10192.18 of the Insurance Code is amended to read:

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

(Statements)

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

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

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

(4) If after purchasing this policy you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your

suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

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

(Questions)

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

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

To the best of your knowledge,

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

Yes____ No____

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

Yes____ No____

(c) If yes, what is the effective date ____________________

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

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

Yes____ No____

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement policy

Yes____ No____

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

Yes____ No____

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

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

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

Yes____ No____

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

Yes____ No____

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

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for direct mailers]

Yes____ No____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy

Yes____ No____

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

Yes____ No____

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

____

____

____

____

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

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

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

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

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

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

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

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement

coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer as provided in Section 10508. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(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.

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

__ Additional benefits that are: ______

__ No change in benefits, but lower premiums.

__ Fewer benefits and lower premiums.

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

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

__ Other reasons specified here: ______

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

2. State law provides that your replacement Medicare supplement policy may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you

sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

____

(Signature of Agent, Broker, or Other Representative)

____

(Signature of Applicant)

____

(Date)

(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 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~~

(g) An issuer shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of, or open enrollment for,

1 *any Medicare supplement coverage pursuant to Section 10192.11*
2 *or 10192.12, except for purposes of paragraph (1) or (2) of*
3 *subdivision (a) of Section 10192.11 when the applicant is first*
4 *enrolled in Medicare Part B. The application form shall include*
5 *a clear and conspicuous statement that the applicant is not required*
6 *to provide health information during a period where guaranteed*
7 *issue or open enrollment applies, as specified in Section 10192.11*
8 *or 10192.12, except for purposes of paragraph (1) or (2) of*
9 *subdivision (a) of Section 10192.11 when the applicant is first*
10 *enrolled in Medicare Part B, and shall inform the applicant of*
11 *those periods of guaranteed issuance of Medicare supplement*
12 *coverage. This subdivision shall not* prohibit an issuer from
13 requiring proof of eligibility for a guaranteed issuance of Medicare
14 supplement coverage.
15 ~~SEC. 27.~~
16 *SEC. 26.* Section 10192.20 of the Insurance Code is amended
17 to read:
18 10192.20. (a) An issuer, directly or through its producers, shall
19 do each of the following:
20 (1) Establish marketing procedures to ensure that any
21 comparison of policies by its agents or other producers will be fair
22 and accurate.
23 (2) Establish marketing procedures to ensure that excessive
24 insurance is not sold or issued.
25 (3) Display prominently by type, stamp, or other appropriate
26 means, on the first page of the policy, the following:
27
28 "Notice to buyer: This policy may not cover all of your medical
29 expenses."
30
31 (4) Inquire and otherwise make every reasonable effort to
32 identify whether a prospective applicant for a Medicare supplement
33 policy already has health insurance and the types and amounts of
34 that insurance.
35 (5) Establish auditable procedures for verifying compliance
36 with this subdivision.
37 (b) In addition to the practices prohibited by this code or any
38 other law, the following acts and practices are prohibited:
39 (1) Twisting, which means knowingly making any misleading
40 representation or incomplete or fraudulent comparison of any

insurance policies or insurers for the purpose of inducing or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 28.~~

SEC. 27. Section 10192.24 is added to the Insurance Code, to read:

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

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

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

(2) The issuer shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to that individual or a family member of the individual.

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

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

(2) Increase the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. For purposes of this paragraph, the manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the premium for the group.

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

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

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

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

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

(h) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual or a family member of that individual, the request, requirement, or purchase shall not be considered a violation of subdivision (g) if the request, requirement, or purchase is not in violation of subdivision (f). However, the issuer shall not use any genetic information obtained under this section for any prohibited purpose described in this section or in Sections 10140 and 10143.

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 29.~~

SEC. 28. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SEC. 30.~~

SEC. 29. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

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

O