

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**

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**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

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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: 2/3. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. ~~Section 1350.1 is added to the Health and Safety~~  
2 ~~Code, to read:~~

3 ~~1350.1. (a) 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

1 not apply to any coverage under any group contract, and (D) is  
2 approved in advance by the director. Any limitations with respect  
3 to a preexisting condition shall appear as a separate paragraph of  
4 the contract and be labeled “Preexisting Condition Limitations.”

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

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

15 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of  
16 Section 1358.8, a Medicare supplement contract with benefits for  
17 outpatient prescription drugs that was issued prior to January 1,  
18 2006, shall be renewed for current enrollees and subscribers, at  
19 their option, who do not enroll in Medicare Part D.

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

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

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

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

33 ~~SEC. 4.~~

34 *SEC. 3.* Section 1358.8 of the Health and Safety Code is  
35 amended to read:

36 1358.8. The following standards are applicable to all Medicare  
37 supplement contracts advertised, solicited, or issued for delivery  
38 on or after January 1, 2001, and with an effective date prior to June  
39 1, 2010. A contract shall not be advertised, solicited, or issued for

1 delivery as a Medicare supplement contract unless it complies with  
2 these benefit standards.

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

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

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

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

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

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

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

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

37 (C) If a group Medicare supplement contract is terminated by  
38 the subscriber and is not replaced as provided under subparagraph  
39 (E), the issuer shall offer enrollees an individual Medicare  
40 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 reinstated

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

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

21 (B) Reinstitution of coverages:

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

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

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

36 (8) If an issuer makes a written offer to the Medicare supplement  
 37 enrollee or subscriber of one or more of its plan contracts, to  
 38 exchange during a specified period from his or her 1990  
 39 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

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

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

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

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

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

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

26 (1) Coverage of Part A Medicare eligible expenses for  
27 hospitalization to the extent not covered by Medicare from the  
28 61st day to the 90th day, inclusive, in any Medicare benefit period.

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

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

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

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

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

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

15 (2) With respect to skilled nursing facility care, coverage for  
16 the actual billed charges up to the coinsurance amount from the  
17 21st day to the 100th day, inclusive, in a Medicare benefit period  
18 for posthospital skilled nursing facility care eligible under Medicare  
19 Part A.

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

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

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

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

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

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

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

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

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

31 (i) Fecal occult blood test.

32 (ii) Mammogram.

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

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

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

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

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

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

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

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

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

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

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

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

35 (iii) Coverage is limited to the following:

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

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

1 21st day to the 100th day, inclusive, in a Medicare benefit period  
2 for posthospital skilled nursing facility care eligible under Medicare  
3 Part A until the out-of-pocket limitation described in paragraph  
4 (8) is met.

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

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

13 (6) Except for coverage provided in paragraph (7), coverage for  
14 75 percent of the cost sharing otherwise applicable under Medicare  
15 Part B after the enrollee or subscriber pays the Part B deductible  
16 until the out-of-pocket limitation described in paragraph (8) is met.

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

20 (8) Coverage of 100 percent of the cost sharing for Medicare  
21 Parts A and B for the balance of the calendar year after the  
22 individual has reached the out-of-pocket limitation on annual  
23 expenditures under Medicare Parts A and B of two thousand dollars  
24 (\$2,000) in 2006, indexed each year by the appropriate inflation  
25 adjustment specified by the secretary.

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

34 ~~SEC. 5.~~

35 *SEC. 4.* Section 1358.81 is added to the Health and Safety  
36 Code, to read:

37 1358.81. The following standards are applicable to all Medicare  
38 supplement contracts delivered or issued for delivery in this state  
39 with an effective date on or after June 1, 2010. No contract may  
40 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.

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

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

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

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

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

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

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

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

33 (6) Termination of a Medicare supplement contract shall be  
34 without prejudice to any continuous loss that commenced while  
35 the contract was in force, but the extension of benefits beyond the  
36 period during which the contract was in force may be predicated  
37 upon the continuous total disability of the enrollee or subscriber,  
38 limited to the duration of the contract benefit period, if any, or  
39 payment of the maximum benefits. Receipt of Medicare Part D  
40 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 reinstated (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 reinstated (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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 ~~SEC. 6.~~

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

27 1358.9. The following standards are applicable to all Medicare  
28 supplement contracts delivered or issued for delivery in this state  
29 on or after July 21, 1992, and with an effective date prior to June  
30 1, 2010.

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

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

38 (c) Benefit plans shall be uniform in structure, language,  
39 designation and format to the standard benefit plans A to J,  
40 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

1 charges, and medically necessary emergency care in a foreign  
2 country as defined in paragraphs (1), (2), (3), (5), and (8) of  
3 subdivision (c) of Section 1358.8, respectively.

4 (7) Standardized Medicare supplement benefit high deductible  
5 plan F shall include only the following: 100 percent of covered  
6 expenses following the payment of the annual high deductible plan  
7 F deductible. The covered expenses include the core benefit, plus  
8 the Medicare Part A deductible, skilled nursing facility care, the  
9 Medicare Part B deductible, 100 percent of the Medicare Part B  
10 excess charges, and medically necessary emergency care in a  
11 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)  
12 of subdivision (c) of Section 1358.8, respectively. The annual high  
13 deductible plan F deductible shall consist of out-of-pocket  
14 expenses, other than premiums, for services covered by the  
15 Medicare supplement plan F policy, and shall be in addition to any  
16 other specific benefit deductibles. The annual high deductible Plan  
17 F deductible shall be one thousand five hundred dollars (\$1,500)  
18 for 1998 and 1999, and shall be based on the calendar year, as  
19 adjusted annually thereafter by the secretary to reflect the change  
20 in the Consumer Price Index for all urban consumers for the  
21 12-month period ending with August of the preceding year, and  
22 rounded to the nearest multiple of ten dollars (\$10).

23 (8) Standardized Medicare supplement benefit plan G shall  
24 include only the following: the core benefit, plus the Medicare  
25 Part A deductible, skilled nursing facility care, 80 percent of the  
26 Medicare Part B excess charges, medically necessary emergency  
27 care in a foreign country, and the at-home recovery benefit as  
28 defined in paragraphs (1), (2), (4), (8), and (10) of subdivision (c)  
29 of Section 1358.8, respectively.

30 (9) Standardized Medicare supplement benefit plan H shall  
31 consist of only the following: the core benefit, plus the Medicare  
32 Part A deductible, skilled nursing facility care, basic outpatient  
33 prescription drug benefit, and medically necessary emergency care  
34 in a foreign country as defined in paragraphs (1), (2), (6), and (8)  
35 of subdivision (c) of Section 1358.8, respectively. The outpatient  
36 prescription drug benefit shall not be included in a Medicare  
37 supplement contract sold on or after January 1, 2006.

38 (10) Standardized Medicare supplement benefit plan I shall  
39 consist of only the following: the core benefit, plus the Medicare  
40 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

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

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

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

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

19 ~~SEC. 7.~~

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

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

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

33 (2) If an issuer makes available any of the additional benefits  
34 described in subdivision (c) of Section 1358.81, or offers  
35 standardized benefit plan K or L, as described in paragraphs (8)  
36 and (9) of subdivision (e), then the issuer shall make available to  
37 each prospective enrollee and subscriber, in addition to a contract  
38 with only the basic (core) benefits as described in paragraph (1),  
39 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

1 medically necessary emergency care in a foreign country, as  
2 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section  
3 1358.81, respectively.

4 (5) Standardized Medicare supplement *benefit* plan F shall  
5 include only the following: the basic (core) benefit as defined in  
6 subdivision (b) of Section 1358.81, plus 100 percent of the  
7 Medicare Part A deductible, skilled nursing facility care, 100  
8 percent of the Medicare Part B deductible, 100 percent of the  
9 Medicare Part B excess charges, and medically necessary  
10 emergency care in a foreign country, as defined in paragraphs (1),  
11 (3), (4), (5), and (6) of subdivision (c) of Section 1358.81,  
12 respectively.

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

17 (A) The basic (core) benefit as defined in subdivision (b) of  
18 Section 1358.81, plus 100 percent of the Medicare Part A  
19 deductible, skilled nursing facility care, 100 percent of the  
20 Medicare Part B deductible, 100 percent of the Medicare Part B  
21 excess charges, and medically necessary emergency care in a  
22 foreign country, as defined in paragraphs (1), (3), (4), (5), and (6)  
23 of subdivision (c) of Section 1358.81, respectively.

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

34 (7) Standardized Medicare supplement benefit plan G shall  
35 include only the following: the basic (core) benefit as defined in  
36 subdivision (b) of Section 1358.81, plus 100 percent of the  
37 Medicare Part A deductible, skilled nursing facility care, 100  
38 percent of the Medicare Part B excess charges, and medically  
39 necessary emergency care in a foreign country, as defined in

1 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section  
2 1358.81, respectively.

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

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

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

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

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

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

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

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

36 (H) Except for coverage provided in subparagraph (I), coverage  
37 for 50 percent of the cost sharing otherwise applicable under  
38 Medicare Part B after the enrollee or subscriber pays the Part B  
39 deductible until the out-of-pocket limitation is met as described  
40 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.

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

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

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

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

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

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

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

27 ~~SEC. 9.~~

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

30 1358.12. (a) (1) With respect to the guaranteed issue of a  
31 Medicare supplement contract, eligible persons are those  
32 individuals described in subdivision (b) who seek to enroll under  
33 the contract during the period specified in subdivision (c), and who  
34 submit evidence of the date of termination or disenrollment or  
35 enrollment in Medicare Part D with the application for a Medicare  
36 supplement contract.

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

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

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

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

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

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

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

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

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

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

33 (D) The Medicare Advantage plan in which the individual is  
34 enrolled reduces any of its benefits or increases the amount of cost  
35 sharing or discontinues for other than good cause relating to quality  
36 of care, its relationship or contract under the plan with a provider  
37 who is currently furnishing services to the individual. An individual  
38 shall be eligible under this subparagraph for a Medicare supplement  
39 contract issued by the same issuer through which the individual  
40 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:

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

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

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

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

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

19 (B) The subsequent enrollment under subparagraph (A) is  
20 terminated by the individual during any period within the first 12  
21 months of the subsequent enrollment (during which the enrollee  
22 is permitted to terminate the subsequent enrollment under Section  
23 1851(e) of the federal Social Security Act).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 ~~SEC. 10.~~

35 *SEC. 9.* Section 1358.13 of the Health and Safety Code is  
36 amended to read:

37 1358.13. (a) An issuer shall comply with Section 1882(c)(3)  
38 of the federal Social Security Act (as enacted by Section  
39 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act

1 of 1987 (OBRA), Public Law 100-203) by doing all of the  
2 following:

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

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

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

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

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

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

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

25 ~~SEC. 11.~~

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

28 1358.17. (a) (1) Medicare supplement contracts shall include  
29 a renewal or continuation provision. The language or specifications  
30 of the provision shall be consistent with subdivision (a) of Section  
31 1365 and the rules adopted thereunder. The provision shall be  
32 appropriately captioned and shall appear on the first page of the  
33 contract, and shall include any reservation by the issuer of the right  
34 to change prepaid or periodic charges and any automatic renewal  
35 increases based on the enrollee's age.

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

39 (b) (1) Except for contract amendments by which the issuer  
40 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

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

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

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

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

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

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

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

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

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

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

6 (j) (1) Issuers shall provide an outline of coverage to all  
7 applicants at the time application is presented to the prospective  
8 applicant and, except for direct response policies, shall obtain an  
9 acknowledgment of receipt of the outline from the applicant. If an  
10 outline of coverage is provided at the time of application and the  
11 Medicare supplement contract is issued on a basis which would  
12 require revision of the outline, a substitute outline of coverage  
13 properly describing the contract shall accompany the contract when  
14 it is delivered and contain the following statement, in no less than  
15 12-point type, immediately above the company name:

16  
17 “NOTICE: Read this outline of coverage carefully. It is not  
18 identical to the outline of coverage provided upon application and  
19 the coverage originally applied for has not been issued.”

20  
21 (2) The outline of coverage provided to applicants pursuant to  
22 this section consists of four parts: a cover page, information about  
23 prepaid or periodic charges, disclosure pages, and charts displaying  
24 the features of each benefit plan offered by the issuer. The outline  
25 of coverage shall be in the language and format prescribed below  
26 in no less than 12-point type. All Medicare supplement plans  
27 authorized by federal law shall be shown on the cover page, and  
28 the plans that are offered by the issuer shall be prominently  
29 identified. Information about prepaid or periodic charges for plans  
30 that are offered shall be shown on the cover page or immediately  
31 following the cover page and shall be prominently displayed. The  
32 charge and mode shall be stated for all plans that are offered to  
33 the prospective applicant. All possible charges for the prospective  
34 applicant shall be illustrated.

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

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

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

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

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

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

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

18 The text shall read: “Medicare supplement contracts can be sold  
 19 in only standard plans. This chart shows the benefits included in  
 20 each plan. Every insurance company must offer Plan A. Some  
 21 plans may not be available. Plans E, H, I, and J are no longer  
 22 available for sale. [This sentence shall not appear after June 1,  
 23 2011.]”

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

26  
 27 INFORMATION ABOUT PREPAID OR PERIODIC  
 28 CHARGES

29  
 30 [Insert plan’s name] can only raise your charges if it raises the  
 31 charge for all contracts like yours in this state. [If the charge is  
 32 based on the increasing age of the enrollee, include information  
 33 specifying when charges will change.]

34  
 35 DISCLOSURES

36  
 37 Use this outline to compare benefits and charges among policies.  
 38 [The following additional language shall be included under  
 39 “DISCLOSURES” for contracts with effective dates on or after  
 40 June 1, 2010, but shall not appear after June 1, 2011.]

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

5  
6 **READ YOUR POLICY VERY CAREFULLY**

7  
8 This is only an outline describing the most important features  
9 of your Medicare supplement plan contract. This is not the plan  
10 contract and only the actual contract provisions will control. You  
11 must read the contract itself to understand all of the rights and  
12 duties of both you and [insert the health care service plan’s name].

13  
14 **RIGHT TO RETURN POLICY**

15  
16 If you find that you are not satisfied with your contract, you may  
17 return it to [insert plan’s address]. If you send the contract back  
18 to us within 30 days after you receive it, we will treat the contract  
19 as if it had never been issued and return all of your payments.

20  
21 **POLICY REPLACEMENT**

22  
23 If you are replacing other health coverage, do NOT cancel it  
24 until you have actually received your new contract and are sure  
25 you want to keep it.

26  
27 **NOTICE**

28  
29 This contract may not fully cover all of your medical costs.  
30 Neither [insert the health care service plan’s name] nor its agents  
31 are connected with Medicare.

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

36  
37 **COMPLETE ANSWERS ARE VERY IMPORTANT**

38  
39 When you fill out the application for the new contract, be sure  
40 to answer truthfully and completely all questions about your

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

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

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

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

28 (m) (1) Any health care service plan contract, other than a  
29 Medicare supplement contract, a contract issued pursuant to a  
30 contract under Section 1876 of the federal Social Security Act (42  
31 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other  
32 contract identified in subdivision (b) of Section 1358.3, issued for  
33 delivery in this state to persons eligible for Medicare, shall notify  
34 enrollees under the contract that the contract is not a Medicare  
35 supplement contract. The notice shall either be printed or attached  
36 to the first page of the outline of coverage delivered to enrollees  
37 under the contract, or if no outline of coverage is delivered, to the  
38 first page of the contract delivered to enrollees. The notice shall  
39 be in no less than 12-point type and shall contain the following  
40 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  
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40

- (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 reinstated 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 reinstated 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 reinstated 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 reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

8

9

(Questions)

10

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

18

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

19

To the best of your knowledge,

20

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

21

Yes\_\_\_ No\_\_\_

22

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

23

Yes\_\_\_ No\_\_\_

24

(c) If yes, what is the effective date \_\_\_\_\_

25

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

27

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

29

Yes\_\_\_ No\_\_\_

30

If yes,

31

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

33

Yes\_\_\_ No\_\_\_

34

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

36

Yes\_\_\_ No\_\_\_

37

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

1 end dates below. If you are still covered under this plan, leave  
2 “END” blank.

3 START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_

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

7 Yes\_\_\_ No\_\_\_

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

9 Yes\_\_\_ No\_\_\_

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

12 Yes\_\_\_ No\_\_\_

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

15 Yes\_\_\_ No\_\_\_

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

18 Yes\_\_\_ No\_\_\_

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

21 Yes\_\_\_ No\_\_\_

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

25 Yes\_\_\_ No\_\_\_

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

27 \_\_\_\_\_  
28 \_\_\_\_\_  
29 \_\_\_\_\_  
30 \_\_\_\_\_

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

32 START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_

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

35

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

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

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

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

6 (d) Upon determining that a sale will involve replacement of  
7 Medicare supplement coverage, any issuer, other than a direct  
8 response issuer, or its agent, shall furnish the applicant, prior to  
9 issuance for delivery of the Medicare supplement contract, a notice  
10 regarding replacement of Medicare supplement coverage. One  
11 copy of the notice signed by the applicant and the agent, except  
12 where the coverage is sold without an agent, shall be provided to  
13 the applicant and an additional signed copy shall be retained by  
14 the issuer. A direct response issuer shall deliver to the applicant  
15 at the time of the issuance of the contract the notice regarding  
16 replacement of Medicare supplement coverage.

17 (e) The notice required by subdivision (d) for an issuer shall be  
18 provided in substantially the following form in no less than  
19 12-point type:

20  
21 NOTICE TO APPLICANT REGARDING REPLACEMENT  
22 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE  
23 ADVANTAGE  
24

25  
26 (Company name and address)  
27

28  
29 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN  
30 THE FUTURE

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

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

4 (1) I have reviewed your current medical or health coverage.  
 5 To the best of my knowledge, the replacement of coverage involved  
 6 in this transaction does not duplicate coverage or, if applicable,  
 7 Medicare Advantage coverage because you intend to terminate  
 8 your existing Medicare supplement coverage or leave your  
 9 Medicare Advantage plan. The replacement contract is being  
 10 purchased for the following reason (check one):\_\_ Additional  
 11 benefits. \_\_No change in benefits, but lower premiums or charges.  
 12 \_\_Fewer benefits and lower premiums or charges.\_\_ Plan has  
 13 outpatient prescription drug coverage and applicant is enrolled in  
 14 Medicare Part D.\_\_ Disenrollment from a Medicare Advantage  
 15 plan. Reasons for disenrollment:\_\_ Other. (please specify)  
 16 \_\_\_\_\_.

17 (2) If the issuer of the Medicare supplement contract being  
 18 applied for does not impose, or is otherwise prohibited from  
 19 imposing, preexisting condition limitations, please skip to statement  
 20 3 below. Health conditions that you may presently have  
 21 (preexisting conditions) may not be immediately or fully covered  
 22 under the new contract. This could result in denial or delay of a  
 23 claim for benefits under the new contract, whereas a similar claim  
 24 might have been payable under your present contract.

25 (3) State law provides that your replacement Medicare  
 26 supplement contract may not contain new preexisting conditions,  
 27 waiting periods, elimination periods, or probationary periods. The  
 28 plan will waive any time periods applicable to preexisting  
 29 conditions, waiting periods, elimination periods, or probationary  
 30 periods in the new coverage for similar benefits to the extent that  
 31 time was spent (depleted) under the original contract.

32 (4) If you still wish to terminate your present policy or contract  
 33 and replace it with new coverage, be certain to truthfully and  
 34 completely answer any and all questions on the application  
 35 concerning your medical and health history. Failure to include all  
 36 material medical information on an application requesting that  
 37 information may provide a basis for the plan to deny any future  
 38 claims and to refund your prepaid or periodic payment as though  
 39 your contract had never been in force. After the application has

1 been completed and before you sign it, review it carefully to be  
2 certain that all information has been properly recorded.

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

6  
7 \_\_\_\_\_  
8 (Signature of Solicitor, Solicitor Firm, or Other Representative)  
9 [Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

10 \_\_\_\_\_  
11 (Applicant's Signature)

12 \_\_\_\_\_  
13 (Date)

14  
15 (f) The application form or other consumer information for  
16 persons eligible for Medicare and used by an issuer shall contain  
17 as an attachment a Medicare supplement buyer's guide in the form  
18 approved by the director. The application or other consumer  
19 information, containing as an attachment the buyer's guide, shall  
20 be mailed or delivered to each applicant applying for that coverage  
21 at or before the time of application and, to establish compliance  
22 with this subdivision, the issuer shall obtain an acknowledgment  
23 of receipt of the attached buyer's guide from each applicant. No  
24 issuer shall make use of or otherwise disseminate any buyer's  
25 guide that does not accurately outline current Medicare supplement  
26 benefits. No issuer shall be required to provide more than one copy  
27 of the buyer's guide to any applicant.

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

36 ~~(h) For an individual who is subject to an open enrollment period~~  
37 ~~or who is guaranteed issuance of any Medicare supplement~~  
38 ~~coverage as described in Section 1358.11 or 1358.12, an issuer~~  
39 ~~shall not require or request health information from an applicant~~  
40 ~~or require or request the applicant to sign a form required by the~~

1 federal Health Insurance Portability and Accountability Act of  
 2 1996. The application form shall include a clear and conspicuous  
 3 statement that the applicant is not required to provide health  
 4 information or to sign a form required by the federal Health  
 5 Insurance Portability and Accountability Act of 1996 during a  
 6 period of open enrollment or guaranteed issuance, as described in  
 7 Section 1358.11 or 1358.12, of any Medicare supplement coverage  
 8 and shall inform the applicant of the periods of open enrollment  
 9 or guaranteed issuance of Medicare supplement coverage. A  
 10 supplementary application or other form containing those  
 11 statements that the applicant and solicitor are required to sign may  
 12 be used for this purpose. This subdivision shall not

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

30 ~~SEC. 13.~~

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

33 1358.20. (a) An issuer, directly or through solicitors or other  
 34 representatives, shall do each of the following:

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

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

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

4  
5 “Notice to buyer: This Medicare supplement contract may not  
6 cover all of your medical expenses.”

7  
8 (4) Inquire and otherwise make every reasonable effort to  
9 identify whether a prospective applicant for a Medicare supplement  
10 contract already has health care coverage and the types and  
11 amounts of that coverage.

12 (5) Provide, on the application form for Medicare supplement  
13 contracts, a statement that reads as follows: “A rate guide is  
14 available that compares the policies sold by different insurers. You  
15 can obtain a copy of this rate guide by calling the Department of  
16 Managed Health Care’s consumer toll-free telephone number  
17 (1-888-HMO-2219), by calling the Health Insurance Counseling  
18 and Advocacy Program (HICAP) toll-free telephone number  
19 (1-800-434-0222), or by accessing the Department of Managed  
20 Health Care’s Internet Web site ([www.dmhc.ca.gov](http://www.dmhc.ca.gov)).”

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

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

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

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

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

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

4 ~~SEC. 14.~~

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

7 1358.24. This section applies to all contracts that become  
8 effective on or after May 21, 2009.

9 (a) In addition to the requirements set forth under Sections  
10 1365.5 and 1374.7, an issuer of a Medicare supplement contract  
11 shall adhere to the requirements imposed by the federal Genetic  
12 Information Nondiscrimination Act of 2008 (Public Law 110-233),  
13 as follows:

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

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

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

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

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

37 (c) An issuer of a Medicare supplement contract shall not request  
38 or require an individual or a family member of that individual to  
39 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

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

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

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

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

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

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

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

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

33 ~~SEC. 15.~~

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

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

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

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

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

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

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

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

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

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

18 (7) Accidental death insurance.

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

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

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

27 ~~SEC. 16.~~

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

30 10192.4. The following definitions apply for the purposes of  
31 this article:

32 (a) "Applicant" means:

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

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

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

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

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

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

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

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

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

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

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

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

28 (F) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

11 (D) Workers’ compensation or similar insurance.

12 (E) Automobile medical payment insurance.

13 (F) Credit-only insurance.

14 (G) Coverage for onsite medical clinics.

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

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

22 (A) Limited scope dental or vision benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (o) “1990 standardized Medicare supplement benefit plan,”  
6 “1990 standardized benefit plan,” or “1990 plan” means a group  
7 or individual policy of Medicare supplement insurance issued on  
8 or after July 21, 1992, and with an effective date prior to June 1,  
9 2010, and includes Medicare supplement insurance policies and  
10 certificates renewed on or after that date which are not replaced  
11 by the issuer at the request of the insured.

12 (p) “2010 standardized Medicare supplement benefit plan,”  
13 “2010 standardized benefit plan,” or “2010 plan” means a group  
14 or individual policy of Medicare supplement insurance issued with  
15 an effective date on or after June 1, 2010.

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

18 ~~SEC. 17.~~

19 *SEC. 16.* Section 10192.6 of the Insurance Code is amended  
20 to read:

21 10192.6. (a) Except for permitted preexisting condition clauses  
22 as described in Sections 10192.7, 10192.8, and 10192.81, a policy  
23 or certificate shall not be advertised, solicited, or issued for delivery  
24 as a Medicare supplement policy if the policy or certificate contains  
25 limitations or exclusions on coverage that are more restrictive than  
26 those of Medicare.

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

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

33 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of  
34 Section 10192.8, a Medicare supplement policy with benefits for  
35 outpatient prescription drugs that was issued prior to January 1,  
36 2006, shall be renewed for current policyholders, at the option of  
37 the policyholder, who do not enroll in Medicare Part D.

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

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

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

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

12 ~~SEC. 18.~~

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

15 10192.8. The following standards are applicable to all Medicare  
16 supplement policies or certificates advertised, solicited, or issued  
17 for delivery on or after January 1, 2001, and with an effective date  
18 prior to June 1, 2010. A policy or certificate shall not be advertised,  
19 solicited, or issued for delivery as a Medicare supplement policy  
20 or certificate unless it complies with these benefit standards.

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

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

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

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

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

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

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

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

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

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

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

35 (ii) If a Medicare supplement policy or certificate replaces  
36 another Medicare supplement policy or certificate that has been  
37 in force for six months or more, the replacing issuer shall not  
38 impose an exclusion or limitation based on a preexisting condition.  
39 If the original coverage has been in force for less than six months,  
40 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 reinstated (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 reinstated, 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, reinstatement 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

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

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

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

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

16 (7) Coverage of the actual cost, up to the legally billed amount,  
17 of an annual cervical cancer screening test as provided in Section  
18 10123.18, to the extent not paid by Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (i) Fecal occult blood test.

13 (ii) Mammogram.

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

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

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

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

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

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

36 (iv) “At-home recovery visit” means the period of a visit  
37 required to provide at-home recovery care, without any limit on  
38 the duration of the visit, except that each consecutive four hours  
39 in a 24-hour period of services provided by a care provider is one  
40 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

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

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

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

15 (5) With respect to skilled nursing facility care, coverage for  
16 50 percent of the coinsurance amount for each day used from the  
17 21st day to the 100th day, inclusive, in a Medicare benefit period  
18 for posthospital skilled nursing facility care eligible under Medicare  
19 Part A until the out-of-pocket limitation described in paragraph  
20 (10) is met.

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

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

31 (8) Except for coverage provided in paragraph (9), coverage for  
32 50 percent of the cost sharing otherwise applicable under Medicare  
33 Part B after the policyholder pays the Part B deductible, until the  
34 out-of-pocket limitation is met as described in paragraph (10).

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

38 (10) Coverage of 100 percent of all cost sharing under Medicare  
39 Parts A and B for the balance of the calendar year after the  
40 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

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

10 ~~SEC. 19.~~

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

13 10192.81. The following standards are applicable to all  
14 Medicare supplement policies or certificates delivered or issued  
15 for delivery in this state with an effective date on or after June 1,  
16 2010. No policy or certificate may be advertised, solicited,  
17 delivered, or issued for delivery in this state as a Medicare  
18 supplement policy or certificate unless it complies with these  
19 benefit standards. No issuer may offer any 1990 standardized  
20 Medicare supplement benefit plan for sale with an effective date  
21 on or after June 1, 2010. Benefit standards applicable to Medicare  
22 supplement policies and certificates issued with an effective date  
23 prior to June 1, 2010, remain subject to the requirements of Section  
24 10192.8.

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

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

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

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

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

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

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

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

13 (B) The issuer shall not cancel or nonrenew the policy for any  
14 reason other than nonpayment of premium or material  
15 misrepresentation which is shown by the issuer to be material to  
16 the acceptance for coverage. The contestability period for Medicare  
17 supplement insurance shall be two years, pursuant to Section  
18 10350.2.

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

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

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

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

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

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

35 (E) (i) If a group Medicare supplement policy is replaced by  
36 another group Medicare supplement policy purchased by the same  
37 policyholder, the issuer of the replacement policy shall offer  
38 coverage to all persons covered under the old group policy on its  
39 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 reinstated (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 reinstated (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) Reinstatement 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

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

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

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

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

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

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

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

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

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

35 (c) The following additional benefits shall be included in  
36 Medicare supplement benefit plans B, C, D, F, ~~F with high~~  
37 ~~deductible~~ *high deductible* F, G, M, and N, consistent with the  
38 plan type and benefits for each plan as provided in Section  
39 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.

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

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

14 (7) Standardized Medicare supplement benefit high deductible  
15 plan F shall include only the following: 100 percent of covered  
16 expenses following the payment of the annual high deductible plan  
17 F deductible. The covered expenses include the core benefit, plus  
18 the Medicare Part A deductible, skilled nursing facility care, the  
19 Medicare Part B deductible, 100 percent of the Medicare Part B  
20 excess charges, and medically necessary emergency care in a  
21 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)  
22 of subdivision (c) of Section 10192.8, respectively. The annual  
23 high deductible plan F deductible shall consist of out-of-pocket  
24 expenses, other than premiums, for services covered by the  
25 Medicare supplement plan F policy, and shall be in addition to any  
26 other specific benefit deductibles. The annual high deductible Plan  
27 F deductible shall be one thousand five hundred dollars (\$1,500)  
28 for 1998 and 1999, and shall be based on the calendar year, as  
29 adjusted annually thereafter by the secretary to reflect the change  
30 in the Consumer Price Index for all urban consumers for the  
31 12-month period ending with August of the preceding year, and  
32 rounded to the nearest multiple of ten dollars (\$10).

33 (8) Standardized Medicare supplement benefit plan G shall  
34 include only the following: the core benefit, plus the Medicare  
35 Part A deductible, skilled nursing facility care, 80 percent of the  
36 Medicare Part B excess charges, medically necessary emergency  
37 care in a foreign country, and the at-home recovery benefit as  
38 defined in paragraphs (1), (2), (4), (8), and (10) of subdivision (c)  
39 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

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

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

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

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

29 ~~SEC. 21.~~

30 *SEC. 20.* Section 10192.91 is added to the Insurance Code, to  
 31 read:

32 10192.91. The following standards are applicable to all  
 33 Medicare supplement policies or certificates delivered or issued  
 34 for delivery in this state with an effective date on or after June 1,  
 35 2010. No policy or certificate may be advertised, solicited,  
 36 delivered, or issued for delivery in this state as a Medicare  
 37 supplement policy or certificate unless it complies with these  
 38 benefit plan standards. Benefit plan standards applicable to  
 39 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

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

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

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

18 (5) Standardized Medicare supplement *benefit* plan F shall  
19 include only the following: the basic (core) benefit as defined in  
20 subdivision (b) of Section 10192.81, plus 100 percent of the  
21 Medicare Part A deductible, the skilled nursing facility care, 100  
22 percent of the Medicare Part B deductible, 100 percent of the  
23 Medicare Part B excess charges, and medically necessary  
24 emergency care in a foreign country as defined in paragraphs (1),  
25 (3), (4), (5), and (6) of subdivision (c) of Section 10192.81,  
26 respectively.

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

31 (A) The covered expenses include the basic (core) benefit as  
32 defined in subdivision (b) of Section 10192.81, plus 100 percent  
33 of the Medicare Part A deductible, skilled nursing facility care,  
34 100 percent of the Medicare Part B deductible, 100 percent of the  
35 Medicare Part B excess charges, and medically necessary  
36 emergency care in a foreign country, as defined in paragraphs (1),  
37 (3), (4), (5), and (6) of subdivision (c) of Section 10192.81,  
38 respectively.

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

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

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

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

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

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

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

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

36 (E) Coverage for 50 percent of the coinsurance amount for each  
37 day used from the 21st day through the 100th day in a Medicare  
38 benefit period for posthospital skilled nursing facility care eligible  
39 under Medicare Part A until the out-of-pocket limitation is met as  
40 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.

1 (11) Standardized Medicare supplement *benefit* plan N shall  
2 include only the following: the basic (core) benefit as defined in  
3 subdivision (b) of Section 10192.81, plus 100 percent of the  
4 Medicare Part A deductible, skilled nursing facility care, and  
5 medically necessary emergency care in a foreign country, as  
6 defined in paragraphs (1), (3), and (6) of subdivision (c) of Section  
7 10192.81, respectively, with copayments in the following amounts:

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

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

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

29 ~~SEC. 22.~~

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

32 10192.11. (a) (1) An issuer shall not deny or condition the  
33 issuance or effectiveness of any Medicare supplement policy or  
34 certificate available for sale in this state, nor discriminate in the  
35 pricing of a policy or certificate because of the health status, claims  
36 experience, receipt of health care, or medical condition of an  
37 applicant in the case of an application for a policy or certificate  
38 that is submitted prior to or during the six-month period beginning  
39 with the first day of the first month in which an individual is both  
40 65 years of age or older and is enrolled for benefits under Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

36 (f) An individual enrolled in Medicare Part B is entitled to open  
37 enrollment described in this section if the individual was covered  
38 under a policy, certificate, or contract providing Medicare  
39 supplement coverage but that coverage terminated because the

1 individual established residence at a location not served by the  
2 plan.

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

11 ~~(h)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (i) Commencing January 1, 2007, an individual enrolled in  
39 Medicare Part B is entitled to open enrollment described in this  
40 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).

- 1 (ii) A similar organization operating under demonstration project  
2 authority, effective for periods before April 1, 1999.
- 3 (iii) An organization under an agreement under Section  
4 1833(a)(1)(A) of the Social Security Act (health care prepayment  
5 plan).
- 6 (iv) An organization under a Medicare Select policy.
- 7 (B) The enrollment ceases under the same circumstances that  
8 would permit discontinuance of an individual's election of coverage  
9 under paragraph (2) or (3).
- 10 (5) The individual is enrolled under a Medicare supplement  
11 policy, and the enrollment ceases because of any of the following  
12 circumstances:
- 13 (A) The insolvency of the issuer or bankruptcy of the nonissuer  
14 organization, or other involuntary termination of coverage or  
15 enrollment under the policy.
- 16 (B) The issuer of the policy substantially violated a material  
17 provision of the policy.
- 18 (C) The issuer, or an agent or other entity acting on the issuer's  
19 behalf, materially misrepresented the policy's provisions in  
20 marketing the policy to the individual.
- 21 (6) The individual meets both of the following conditions:
- 22 (A) The individual was enrolled under a Medicare supplement  
23 policy and terminates enrollment and subsequently enrolls, for the  
24 first time, with any Medicare Advantage organization under a  
25 Medicare Advantage plan under Medicare Part C, any eligible  
26 organization under a contract under Section 1876 of the Social  
27 Security Act (Medicare cost), any similar organization operating  
28 under demonstration project authority, any PACE provider under  
29 Section 1894 of the Social Security Act, or a Medicare Select  
30 policy.
- 31 (B) The subsequent enrollment under subparagraph (A) is  
32 terminated by the individual during any period within the first 12  
33 months of the subsequent enrollment (during which the enrollee  
34 is permitted to terminate the subsequent enrollment under Section  
35 1851(e) of the federal Social Security Act).
- 36 (7) The individual upon first becoming eligible for benefits  
37 under Medicare Part A at 65 years of age, enrolls in a Medicare  
38 Advantage plan under Medicare Part C or with a PACE provider  
39 under Section 1894 of the Social Security Act, and disenrolls from

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

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

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

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

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

19 (2) In the case of an individual described in paragraphs (2), (3),  
20 (4), (6), and (7) of subdivision (b) whose enrollment is terminated  
21 involuntarily, the guaranteed issue period begins on the date that  
22 the individual receives a notice of termination and ends 63 days  
23 after the date the applicable coverage is terminated.

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

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

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

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

38 (5) In the case of an individual described in paragraph (8) of  
39 subdivision (b), the guaranteed issue period begins on the date the  
40 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:

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

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

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

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

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

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

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

19 ~~SEC. 25.~~

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

22 10192.17. (a) Medicare supplement policies and certificates  
23 shall include a renewal, continuation, or conversion provision. The  
24 language or specifications of the provision shall be consistent with  
25 the type of contract issued. The provision shall be appropriately  
26 captioned and shall appear on the first page of the policy, and shall  
27 include any reservation by the issuer of the right to change  
28 premiums and any automatic renewal premium increases based  
29 on the policyholder's age.

30 (b) Except for riders or endorsements by which the issuer  
31 effectuates a request made in writing by the insured, exercises a  
32 specifically reserved right under a Medicare supplement policy,  
33 or is required to reduce or eliminate benefits to avoid duplication  
34 of Medicare benefits, all riders or endorsements added to a  
35 Medicare supplement policy after the date of issue or upon  
36 reinstatement or renewal that reduce or eliminate benefits or  
37 coverage in the policy shall require a signed acceptance by the  
38 insured. After the date of policy or certificate issue, any rider or  
39 endorsement that increases benefits or coverage with a concomitant  
40 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

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

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

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

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

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

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

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

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

1  
2 “NOTICE: Read this outline of coverage carefully. It is not  
3 identical to the outline of coverage provided upon application and  
4 the coverage originally applied for has not been issued.”  
5

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

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

24 (k) (1) Any disability insurance policy or certificate, a basic,  
25 catastrophic or major medical expense policy, or single premium  
26 nonrenewal policy or certificate issued to persons eligible for  
27 Medicare, other than a Medicare supplement policy, a policy issued  
28 pursuant to a contract under Section 1876 of the federal Social  
29 Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income  
30 policy, or any other policy identified in subdivision (b) of Section  
31 10192.3, advertised, solicited, or issued for delivery in this state  
32 to persons eligible for Medicare, shall notify insureds under the  
33 policy that the policy is not a Medicare supplement policy or  
34 certificate. The notice shall either be printed or attached to the first  
35 page of the outline of coverage delivered to insureds under the  
36 policy, or if no outline of coverage is delivered, to the first page  
37 of the policy or certificate delivered to insureds. The notice shall  
38 be in no less than 12-point type and shall contain the following  
39 language:  
40

1 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE  
2 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible  
3 for Medicare, review the Guide to Health Insurance for People  
4 with Medicare available from the company.”  
5

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

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

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

26 (2) If an outline of coverage is provided at or before the time  
27 of application and the Medicare supplement policy or certificate  
28 is issued on a basis that would require revision of the outline, a  
29 substitute outline of coverage properly describing the policy or  
30 certificate shall accompany the policy or certificate when it is  
31 delivered and contain the following statement, in no less than  
32 12-point type, immediately above the name:  
33

34 “NOTICE: Read this outline of coverage carefully. It is not  
35 identical to the outline of coverage provided upon application and  
36 the coverage originally applied for has not been issued.”  
37

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

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

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

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

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

14

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

19 The BASIC BENEFITS included in ALL plans are:

20 Hospitalization: Medicare Part A coinsurance plus coverage for  
21 365 additional days after Medicare benefits end.

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

24 Blood: First three pints of blood each year.

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

27 Cervical cancer test: One annual screening.”

28

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

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

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

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

7  
8 “Medicare supplement insurance can be sold in only standard  
9 plans. This chart shows the benefits included in each plan. Every  
10 insurance company must offer Plan A. Some plans may not be  
11 available. Plans E, H, I and J are no longer available for sale. [This  
12 sentence shall not appear after June 1, 2011.]

13 The BASIC BENEFITS included in ALL plans are:

14 Hospitalization: Medicare Part A coinsurance plus coverage for  
15 365 additional days after Medicare benefits end.

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

20 Blood: First three pints of blood each year.

21 Hospice: Part A coinsurance.

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

24 Cervical cancer test: One annual screening.”

25  
26 [Reference to the mammogram and cervical cancer screening  
27 test shall not be included so long as California is required to  
28 disallow them for Medicare beneficiaries by the Centers for  
29 Medicare and Medicaid Services or other agent of the federal  
30 government under 42 U.S.C. Sec. 1395ss.]

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

1 raise your premium if we raise the premium for all policies like  
2 yours in California.”

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

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

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

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

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

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

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

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

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

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

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

15 ~~SEC. 26.~~

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

18 10192.18. (a) Application forms shall include the following  
19 questions designed to elicit information as to whether, as of the  
20 date of the application, the applicant currently has Medicare  
21 supplement, Medicare Advantage, Medi-Cal coverage, or another  
22 health insurance policy or certificate in force or whether a Medicare  
23 supplement policy or certificate is intended to replace any other  
24 disability policy or certificate presently in force. A supplementary  
25 application or other form to be signed by the applicant and agent  
26 containing those questions and statements may be used.

27

28

(Statements)

29

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

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

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

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

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

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

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

(Questions)

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

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

To the best of your knowledge,

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

Yes \_\_\_ No \_\_\_

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

Yes \_\_\_ No \_\_\_

(c) If yes, what is the effective date \_\_\_\_\_

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

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

Yes \_\_\_ No \_\_\_

If yes,

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

Yes \_\_\_ No \_\_\_

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

Yes \_\_\_ No \_\_\_

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

START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_

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

Yes \_\_\_ No \_\_\_

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

Yes \_\_\_ No \_\_\_

1 (d) Did you drop a Medicare supplement policy to enroll in the  
 2 Medicare plan  
 3 Yes\_\_\_ No\_\_\_  
 4 (4) (a) Do you have another Medicare supplement policy in  
 5 force  
 6 Yes\_\_\_ No\_\_\_  
 7 (b) If so, with what company, and what plan do you have  
 8 [optional for direct mailers]  
 9 Yes\_\_\_ No\_\_\_  
 10 (c) If so, do you intend to replace your current Medicare  
 11 supplement policy with this policy  
 12 Yes\_\_\_ No\_\_\_  
 13 (5) Have you had coverage under any other health insurance  
 14 within the past 63 days (For example, an employer, union, or  
 15 individual plan)  
 16 Yes\_\_\_ No\_\_\_  
 17 (a) If so, with what companies and what kind of policy  
 18 \_\_\_\_\_  
 19 \_\_\_\_\_  
 20 \_\_\_\_\_  
 21 \_\_\_\_\_  
 22 (b) What are your dates of coverage under the other policy  
 23 START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_  
 24 (If you are still covered under the other policy, leave “END”  
 25 blank.)  
 26  
 27 (b) Agents shall list any other health insurance policies they  
 28 have sold to the applicant as follows:  
 29 (1) List policies sold that are still in force.  
 30 (2) List policies sold in the past five years that are no longer in  
 31 force.  
 32 (c) In the case of a direct response issuer, a copy of the  
 33 application or supplemental form, signed by the applicant, and  
 34 acknowledged by the issuer, shall be returned to the applicant by  
 35 the issuer upon delivery of the policy.  
 36 (d) Upon determining that a sale will involve replacement of  
 37 Medicare supplement coverage, any issuer, other than a direct  
 38 response issuer, or its agent, shall furnish the applicant, prior to  
 39 issuance for delivery of the Medicare supplement policy or  
 40 certificate, a notice regarding replacement of Medicare supplement

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

8 (e) The notice required by subdivision (d) for an issuer shall be  
9 in the form specified by the commissioner, using, to the extent  
10 practicable, a model notice prepared by the National Association  
11 of Insurance Commissioners for this purpose. The replacement  
12 notice shall be printed in no less than 12-point type in substantially  
13 the following form:

14  
15 [Insurer's name and address]

16  
17 NOTICE TO APPLICANT REGARDING REPLACEMENT  
18 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE  
19 ADVANTAGE

20  
21 SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE  
22 FUTURE.

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

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

34 If you want to discuss buying Medicare supplement or Medicare  
35 Advantage coverage with a trained insurance counselor, call the  
36 California Department of Insurance's toll-free telephone number  
37 1-800-927-HELP, and ask how to contact your local Health  
38 Insurance Counseling and Advocacy Program (HICAP) office.  
39 HICAP is a service provided free of charge by the State of  
40 California.

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

- 10  Additional benefits that are: \_\_\_\_\_
- 11  No change in benefits, but lower premiums.
- 12  Fewer benefits and lower premiums.
- 13  Plan has outpatient prescription drug coverage and applicant  
 14 is enrolled in Medicare Part D.
- 15  Disenrollment from a Medicare Advantage plan. Reasons for  
 16 disenrollment:
- 17  Other reasons specified here: \_\_\_\_\_

18 1. Note: If the issuer of the Medicare supplement policy being  
 19 applied for does not impose, or is otherwise prohibited from  
 20 imposing, preexisting condition limitations, please skip to statement  
 21 3 below. Health conditions that you may presently have  
 22 (preexisting conditions) may not be immediately or fully covered  
 23 under the new policy. This could result in denial or delay of a claim  
 24 for benefits under the new policy, whereas a similar claim might  
 25 have been payable under your present policy.

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

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

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

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

7  
8 \_\_\_\_\_  
9 (Signature of Agent, Broker, or Other Representative)

10 \_\_\_\_\_  
11 (Signature of Applicant)

12 \_\_\_\_\_  
13 (Date)

14  
15

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

21 ~~(g) For an individual who is subject to an open enrollment period  
22 or who is guaranteed issuance of any Medicare supplement  
23 coverage as described in Section 10192.11 or 10192.12, an issuer  
24 shall not require or request health information from an applicant  
25 or require or request the applicant to sign a form required by the  
26 federal Health Insurance Portability and Accountability Act of  
27 1996. The application form shall include a clear and conspicuous  
28 statement that the applicant is not required to provide health  
29 information or to sign a form required by the federal Health  
30 Insurance Portability and Accountability Act of 1996 during a  
31 period of open enrollment or guaranteed issuance, as described in  
32 Section 10192.11 or 10192.12, of any Medicare supplement  
33 coverage and shall inform the applicant of the periods of open  
34 enrollment or guaranteed issuance of Medicare supplement  
35 coverage. A supplementary application or other form containing  
36 those statements that the applicant and solicitor are required to  
37 sign may be used for this purpose. This subdivision shall not~~

38 *(g) An issuer shall not require, request, or obtain health*  
39 *information as part of the application process for an applicant*  
40 *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

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

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

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

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

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

25 (1) (A) For policies sold for effective dates prior to June 1,  
26 2010, a listing of all the policies, plans A to L, inclusive, that are  
27 available from the company.

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

32 (2) (A) For policies sold for effective dates prior to June 1,  
33 2010, a listing of all the policies, plans A to L, inclusive, for  
34 Medicare beneficiaries under the age of 65 that are available from  
35 the company.

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

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

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

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

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

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

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

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

17 (3) On the department’s Internet Web site.

18 (4) In addition to the distribution methods described in  
19 paragraphs (1) to (3), inclusive, each insurer that markets Medicare  
20 supplement insurance or Medicare supplement contracts in this  
21 state shall provide on the application form a statement that reads  
22 as follows: “A rate guide is available that compares the policies  
23 sold by different insurers. You can obtain a copy of this rate guide  
24 by calling the Department of Insurance’s consumer toll-free  
25 telephone number (1-800-927-HELP), by calling the Health  
26 Insurance Counseling and Advocacy Program (HICAP) toll-free  
27 telephone number (1-800-434-0222), or by accessing the  
28 Department of Insurance’s Internet Web site  
29 ([www.insurance.ca.gov](http://www.insurance.ca.gov)).”

30 ~~SEC. 28.~~

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

33 10192.24. This section applies to all policies with policy years  
34 beginning on or after May 21, 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 ~~SEC. 29.~~

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

29 ~~SEC. 30.~~

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

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