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AMENDED IN ASSEMBLY APRIL 20, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1543

**Introduced by Assembly Members Jones and Fletcher
(Coauthors: Assembly Members Adams, Ammiano, Block, Carter,
Conway, De La Torre, Emmerson, Hall, Hayashi, Hernandez,
Bonnie Lowenthal, Nava, V. Manuel Perez, Salas, and
Audra Strickland)**

March 4, 2009

An act to amend Sections 1358.4, 1358.6, 1358.8, 1358.9, 1358.11, 1358.12, 1358.13, 1358.17, 1358.18, and 1358.20 of, and to add Sections 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, Jones. Medicare supplement coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health

care service plans by the Department of Managed Health Care 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 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 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 either* the plan ~~either~~ terminates or ceases to provide all of those supplemental

health benefits, ~~and~~ or 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.

Existing law provides that an individual enrolled in Medicare Part B is entitled to open enrollment for Medicare supplement coverage upon being notified that he or she is no longer eligible for benefits under the Medi-Cal program.

This bill would also make an individual enrolled in Medicare Part B entitled to open enrollment if he or she is only eligible for Medi-Cal benefits with a share of cost and he or she certifies, at the time of application, that he or she has not met the share of cost.

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

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

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

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

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

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. Section 1358.4 of the Health and Safety Code is
2 amended to read:
3 1358.4. The following definitions apply for the purposes of
4 this article:
5 (a) “Applicant” means:
6 (1) An individual enrollee who seeks to contract for health
7 coverage, in the case of an individual Medicare supplement
8 contract.
9 (2) An enrollee who seeks to obtain health coverage through a
10 group, in the case of a group Medicare supplement contract.
11 (b) “Bankruptcy” means that situation in which a Medicare
12 Advantage organization that is not an issuer has filed, or has had
13 filed against it, a petition for declaration of bankruptcy and has
14 ceased doing business in the state.
15 (c) “Continuous period of creditable coverage” means the period
16 during which an individual was covered by creditable coverage,
17 if during the period of the coverage the individual had no breaks
18 in coverage greater than 63 days.
19 (d) (1) “Creditable coverage” means, with respect to an
20 individual, coverage of the individual provided under any of the
21 following:
22 (A) Any individual or group contract, policy, certificate, or
23 program that is written or administered by a health care service
24 plan, health insurer, fraternal benefits society, self-insured
25 employer plan, or any other entity, in this state or elsewhere, and
26 that arranges or provides medical, hospital, and surgical coverage
27 not designed to supplement other private or governmental plans.
28 The term includes continuation or conversion coverage.
29 (B) Part A or B of Title XVIII of the federal Social Security
30 Act (Medicare).
31 (C) Title XIX of the federal Social Security Act (medicaid),
32 other than coverage consisting solely of benefits under Section
33 1928 of that act.
34 (D) Chapter 55 of Title 10 of the United States Code
35 (CHAMPUS).

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

3 (F) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

24 (D) Workers' compensation or similar insurance.

25 (E) Automobile medical payment insurance.

26 (F) Credit-only insurance.

27 (G) Coverage for onsite medical clinics.

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

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

34 (A) Limited scope dental or vision benefits.

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

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

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

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

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

3 (5) “Creditable coverage” shall not include the following if
4 offered as a separate policy, certificate, or contract:

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

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

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

11 (e) “Employee welfare benefit plan” means a plan, fund, or
12 program of employee benefits as defined in Section 1002 of Title
13 29 of the United States Code (Employee Retirement Income
14 Security Act).

15 (f) “Insolvency” means when an issuer, licensed to transact the
16 business of a health care service plan in this state, has had a final
17 order of liquidation entered against it with a finding of insolvency
18 by a court of competent jurisdiction in the issuer’s state of domicile.

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

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

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

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

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

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

36 (j) “Medicare supplement contract” means a group or individual
37 plan contract of hospital and medical service associations or health
38 care service plans, other than a contract issued pursuant to a
39 contract under Section 1876 of the federal Social Security Act (42
40 U.S.C.A. Section 1395mm) or an issued contract under a

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

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

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

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

SEC. 2. Section 1358.6 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

(A) The contract is modified to eliminate outpatient prescription drug coverage for outpatient prescription drug expenses incurred

1 after the effective date of the individual's coverage under a
2 Medicare Part D plan.

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

6 SEC. 3. Section 1358.8 of the Health and Safety Code is
7 amended to read:

8 1358.8. The following standards are applicable to all Medicare
9 supplement contracts advertised, solicited, or issued for delivery
10 on or after January 1, 2001, and with an effective date prior to June
11 1, 2010. A contract shall not be advertised, solicited, or issued for
12 delivery as a Medicare supplement contract unless it complies with
13 these benefit standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of the maximum benefits. Receipt of Medicare Part D benefits
2 shall not be considered in determining a continuous loss.

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

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

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

33 (B) Reinstitution of coverages:

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

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

1 prescription drugs but shall otherwise provide coverage that is
2 substantially equivalent to the coverage in effect before the date
3 of suspension.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (1) Coverage of Part A Medicare eligible expenses for
38 hospitalization to the extent not covered by Medicare from the
39 61st day to the 90th day, inclusive, in any Medicare benefit period.

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

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

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

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

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

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

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

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

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

39 (5) With respect to 100 percent of the Medicare Part B excess
40 charges, coverage for all of the difference between the actual

1 Medicare Part B charge as billed, not to exceed any charge
2 limitation established by the Medicare Program or state law, and
3 the Medicare-approved Part B charge.

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

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

20 (8) 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 two
28 hundred fifty dollars (\$250), and a lifetime maximum benefit of
29 fifty thousand dollars (\$50,000). For purposes of this benefit,
30 “emergency care” shall mean care needed immediately because
31 of an injury or an illness of sudden and unexpected onset.

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

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

38 (B) The following screening tests or preventive services that
39 are not covered by Medicare, the selection and frequency of which

1 are determined to be medically appropriate by the attending
2 physician:

3 (i) Fecal occult blood test.

4 (ii) Mammogram.

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

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

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

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

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

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

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

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

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

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

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

7 (iii) Coverage is limited to the following:

8 (I) No more than the number and type of at-home recovery visits
9 certified as necessary by the covered person's attending physician.

10 The total number of at-home recovery visits shall not exceed the
11 number of Medicare-approved home health care visits under a
12 Medicare-approved home care plan of treatment.

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

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

17 (IV) Seven visits in any one week.

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

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

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

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

27 (C) Coverage is excluded for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 dollars (\$4,000) in 2006, indexed each year by the appropriate
2 inflation adjustment specified by the secretary.

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

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

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

11 (3) With respect to skilled nursing facility care, coverage for
12 75 percent of the coinsurance amount for each day used from the
13 21st day to the 100th day, inclusive, in a Medicare benefit period
14 for posthospital skilled nursing facility care eligible under Medicare
15 Part A until the out-of-pocket limitation described in paragraph
16 (8) is met.

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

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

25 (6) Except for coverage provided in paragraph (7), coverage for
26 75 percent of the cost sharing otherwise applicable under Medicare
27 Part B after the enrollee or subscriber pays the Part B deductible
28 until the out-of-pocket limitation described in paragraph (8) is met.

29 (7) Coverage for 100 percent of the cost sharing for Medicare
30 Part B preventive services after the enrollee or subscriber pays the
31 Part B deductible.

32 (8) Coverage of 100 percent of the cost sharing for Medicare
33 Parts A and B for the balance of the calendar year after the
34 individual has reached the out-of-pocket limitation on annual
35 expenditures under Medicare Parts A and B of two thousand dollars
36 (\$2,000) in 2006, indexed each year by the appropriate inflation
37 adjustment specified by the secretary.

38 (f) A contract shall not contain any provision delaying the
39 effective date of coverage beyond the first day of the month
40 following the date of receipt by the issuer of the applicant’s

1 properly completed application, except that the effective date of
2 coverage may be delayed until the 65th birthday of an applicant
3 who is to become eligible for Medicare by reason of age if the
4 application is received any time during the three months
5 immediately preceding the applicant's 65th birthday.

6 SEC. 4. Section 1358.81 is added to the Health and Safety
7 Code, to read:

8 1358.81. The following standards are applicable to all Medicare
9 supplement contracts delivered or issued for delivery in this state
10 with an effective date on or after June 1, 2010. No contract may
11 be advertised, solicited, delivered, or issued for delivery in this
12 state as a Medicare supplement contract unless it complies with
13 these benefit standards. No issuer may offer any 1990 standardized
14 Medicare supplement contract for sale with an effective date on
15 or after June 1, 2010. Benefit standards applicable to Medicare
16 supplement contracts issued with an effective date before June 1,
17 2010, remain subject to the requirements of Section 1358.8.

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

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

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

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

37 (4) A Medicare supplement contract shall not provide for
38 termination of coverage of a spouse solely because of the
39 occurrence of an event specified for termination of coverage of

1 the enrollee or subscriber, other than the nonpayment of prepaid
2 or periodic charges.

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

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

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

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

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

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

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

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

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

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

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

1 in force for less than six months, the replacing issuer shall waive
2 any time period applicable to preexisting conditions, waiting
3 periods, elimination periods, or probationary periods in the new
4 contract to the extent the time was spent under the original
5 coverage.

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

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

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

35 (iii) Each Medicare supplement contract shall provide that
36 benefits and prepaid or periodic charges under the contract shall
37 be suspended (for any period that may be provided by federal
38 regulation) at the request of the enrollee or subscriber if the enrollee
39 or subscriber is entitled to benefits under Section 226(b) of the
40 Social Security Act and is covered under a group health plan (as

1 defined in Section 1862(b)(1)(A)(v) of the Social Security Act).
2 If suspension occurs and if the enrollee or subscriber loses coverage
3 under the group health plan, the contract shall be automatically
4 reinstituted (effective as of the date of loss of coverage) if the
5 enrollee or subscriber provides notice of loss of coverage within
6 90 days after the date of the loss and pays the applicable prepaid
7 or periodic charge.

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

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

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

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

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

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

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

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

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

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

38 (C) The notice of benefit modifications and any adjustments to
39 the prepaid or periodic charges shall be in outline form and in clear

1 and simple terms so as to facilitate comprehension. The notice
2 shall not contain or be accompanied by any solicitation.

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

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

16 (1) Coverage of Part A Medicare eligible expenses for
17 hospitalization to the extent not covered by Medicare from the
18 61st day through the 90th day, inclusive, in any Medicare benefit
19 period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Standardized Medicare supplement benefit plan D shall include only the following: the core benefit, plus the Medicare

1 Part A deductible, skilled nursing facility care, medically necessary
2 emergency care in a foreign country, and the at-home recovery
3 benefit as defined in paragraphs (1), (2), (8), and (10) of
4 subdivision (c) of Section 1358.8, respectively.

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

11 (6) Standardized Medicare supplement benefit plan F shall
12 include only the following: the core benefit, plus the Medicare
13 Part A deductible, the skilled nursing facility care, the Medicare
14 Part B deductible, 100 percent of the Medicare Part B excess
15 charges, and medically necessary emergency care in a foreign
16 country as defined in paragraphs (1), (2), (3), (5), and (8) of
17 subdivision (c) of Section 1358.8, respectively.

18 (7) Standardized Medicare supplement benefit high deductible
19 plan F shall include only the following: 100 percent of covered
20 expenses following the payment of the annual high deductible plan
21 F deductible. The covered expenses include the core benefit, plus
22 the Medicare Part A deductible, skilled nursing facility care, the
23 Medicare Part B deductible, 100 percent of the Medicare Part B
24 excess charges, and medically necessary emergency care in a
25 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
26 of subdivision (c) of Section 1358.8, respectively. The annual high
27 deductible plan F deductible shall consist of out-of-pocket
28 expenses, other than premiums, for services covered by the
29 Medicare supplement plan F policy, and shall be in addition to any
30 other specific benefit deductibles. The annual high deductible Plan
31 F deductible shall be one thousand five hundred dollars (\$1,500)
32 for 1998 and 1999, and shall be based on the calendar year, as
33 adjusted annually thereafter by the secretary to reflect the change
34 in the Consumer Price Index for all urban consumers for the
35 12-month period ending with August of the preceding year, and
36 rounded to the nearest multiple of ten dollars (\$10).

37 (8) Standardized Medicare supplement benefit plan G shall
38 include only the following: the core benefit, plus the Medicare
39 Part A deductible, skilled nursing facility care, 80 percent of the
40 Medicare Part B excess charges, medically necessary emergency

1 care in a foreign country, and the at-home recovery benefit as
2 defined in paragraphs (1), (2), (4), (8), and (10) of subdivision (c)
3 of Section 1358.8, respectively.

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

12 (10) Standardized Medicare supplement benefit plan I shall
13 consist of only the following: the core benefit, plus the Medicare
14 Part A deductible, skilled nursing facility care, 100 percent of the
15 Medicare Part B excess charges, basic outpatient prescription drug
16 benefit, medically necessary emergency care in a foreign country,
17 and at-home recovery benefit as defined in paragraphs (1), (2),
18 (5), (6), (8), and (10) of subdivision (c) of Section 1358.8,
19 respectively. The outpatient prescription drug benefit shall not be
20 included in a Medicare supplement contract sold on or after January
21 1, 2006.

22 (11) Standardized Medicare supplement benefit plan J shall
23 consist of only the following: the core benefit, plus the Medicare
24 Part A deductible, skilled nursing facility care, Medicare Part B
25 deductible, 100 percent of the Medicare Part B excess charges,
26 extended outpatient prescription drug benefit, medically necessary
27 emergency care in a foreign country, preventive medical care, and
28 at-home recovery benefit as defined in paragraphs (1), (2), (3),
29 (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8,
30 respectively. The outpatient prescription drug benefit shall not be
31 included in a Medicare supplement contract sold on or after January
32 1, 2006.

33 (12) Standardized Medicare supplement benefit high deductible
34 plan J shall consist of only the following: 100 percent of covered
35 expenses following the payment of the annual high deductible plan
36 J deductible. The covered expenses include the core benefit, plus
37 the Medicare Part A deductible, skilled nursing facility care,
38 Medicare Part B deductible, 100 percent of the Medicare Part B
39 excess charges, extended outpatient prescription drug benefit,
40 medically necessary emergency care in a foreign country,

preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

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

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

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

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

1358.91. The following standards are applicable to all Medicare supplement contracts delivered or issued for delivery in this state with an effective date on or after June 1, 2010. No contract may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement contract unless it complies with these benefit plan standards. Benefit plan standards applicable to

1 Medicare supplement contracts issued with an effective date before
2 June 1, 2010, remain subject to the requirements of Section 1358.9.

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

6 (2) If an issuer makes available any of the additional benefits
7 described in subdivision (c) of Section 1358.81, or offers
8 standardized benefit plan K or L, as described in paragraphs (8)
9 and (9) of subdivision (e), then the issuer shall make available to
10 each prospective enrollee and subscriber, in addition to a contract
11 with only the basic (core) benefits as described in paragraph (1),
12 a contract containing either standardized benefit plan C, as
13 described in paragraph (3) of subdivision (e), or standardized
14 benefit plan F, as described in paragraph (5) of subdivision (e).

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

19 (c) Benefit plans shall be uniform in structure, language,
20 designation, and format to the standard benefit plans listed in
21 subdivision (e) and conform to the definitions in Section 1358.4.
22 Each benefit shall be structured in accordance with the format
23 provided in subdivisions (b) and (c) of Section 1358.81; or, in the
24 case of plan K or L, in paragraphs (8) or (9) of subdivision (e) of
25 Section 1358.91 and list the benefits in the order shown in
26 subdivision (e). For purposes of this section, “structure, language,
27 and format” means style, arrangement, and overall content of a
28 benefit.

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

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

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

37 (2) Standardized Medicare supplement benefit plan B 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

1 Medicare Part A deductible as defined in paragraph (1) of
2 subdivision (c) of Section 1358.81.

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 1358.81, 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 1358.81, respectively.

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

17 (5) Standardized Medicare supplement benefit plan F shall
18 include only the following: the basic (core) benefit as defined in
19 subdivision (b) of Section 1358.81, plus 100 percent of the
20 Medicare Part A deductible, skilled nursing facility care, 100
21 percent of the Medicare Part B deductible, 100 percent of the
22 Medicare Part B excess charges, and medically necessary
23 emergency care in a foreign country, as defined in paragraphs (1),
24 (3), (4), (5), and (6) of subdivision (c) of Section 1358.81,
25 respectively.

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

30 (A) The basic (core) benefit as defined in subdivision (b) of
31 Section 1358.81, plus 100 percent of the Medicare Part A
32 deductible, skilled nursing facility care, 100 percent of the
33 Medicare Part B deductible, 100 percent of the Medicare Part B
34 excess charges, and medically necessary emergency care in a
35 foreign country, as defined in paragraphs (1), (3), (4), (5), and (6)
36 of subdivision (c) of Section 1358.81, respectively.

37 (B) The annual deductible in high deductible plan F shall consist
38 of out-of-pocket expenses, other than premiums, for services
39 covered by plan F, and shall be in addition to any other specific
40 benefit deductibles. The basis for the deductible shall be one

1 thousand five hundred dollars (\$1,500) and shall be adjusted
2 annually from 1999 by the Secretary of the United States
3 Department of Health and Human Services to reflect the change
4 in the Consumer Price Index for all urban consumers for the
5 12-month period ending with August of the preceding year, and
6 rounded to the nearest multiple of ten dollars (\$10).

7 (7) Standardized Medicare supplement benefit plan G shall
8 include only the following: the basic (core) benefit as defined in
9 subdivision (b) of Section 1358.81, plus 100 percent of the
10 Medicare Part A deductible, skilled nursing facility care, 100
11 percent of the Medicare Part B excess charges, and medically
12 necessary emergency care in a foreign country, as defined in
13 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section
14 1358.81, respectively.

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

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

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

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

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

34 (E) Coverage for 50 percent of the coinsurance amount for each
35 day used from the 21st day through the 100th day in a Medicare
36 benefit period for posthospital skilled nursing facility care eligible
37 under Medicare Part A until the out-of-pocket limitation is met as
38 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 enrollee or subscriber pays the Part B
13 deductible until the out-of-pocket limitation is met as described
14 in subparagraph (J).

15 (I) Coverage of 100 percent of the cost sharing for Medicare
16 Part B preventive services after the enrollee or subscriber pays the
17 Part B 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 1358.81, plus 50 percent of the Medicare
37 Part A deductible, skilled nursing facility care, and medically
38 necessary emergency care in a foreign country, as defined in
39 paragraphs (2), (3), and (6) of subdivision (c) of Section 1358.81,
40 respectively.

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

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

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

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

SEC. 7. Section 1358.11 of the Health and Safety Code is amended to read:

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

1 made available to all applicants who qualify under this subdivision
2 and who are 65 years of age or older.

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

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

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

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

32 (c) Except as provided in subdivision (b) and Section 1358.23,
33 subdivision (a) shall not be construed as preventing the exclusion
34 of benefits under a contract, during the first six months, based on
35 a preexisting condition for which the enrollee received treatment
36 or was otherwise diagnosed during the six months before the
37 coverage became effective.

38 (d) An individual enrolled in Medicare by reason of disability
39 shall be entitled to open enrollment described in this section for
40 six months after the date of his or her enrollment in Medicare Part

1 B, or if notified retroactively of his or her eligibility for Medicare,
2 for six months following notice of eligibility. Sales during the
3 open enrollment period shall not be discouraged by any means,
4 including the altering of the commission structure.

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

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

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

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

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

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

33 (g) (1) An individual whose coverage was terminated by a
34 Medicare Advantage plan shall be entitled to an additional 60-day
35 open enrollment period to be added on to and run consecutively
36 after any open enrollment period authorized by federal law or
37 regulation, for any and all Medicare supplement coverage available
38 on a guaranteed basis under state and federal law or regulations
39 for persons terminated by their Medicare Advantage plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) He or she is no longer eligible for Medi-Cal benefits.

1 (2) *He or she is only eligible for Medi-Cal benefits with a share*
2 *of cost and certifies at the time of application that he or she has*
3 *not met the share of cost.*

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

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

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 contract 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 contract because of health status, claims experience, receipt of
20 health care, or medical condition.

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

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 Medicare and either of the following apply:*

28 (A) *The plan either terminates or ceases to provide all of those*
29 *supplemental health benefits to the individual, and the individual.*

30 (B) *The employer no longer provides the individual with*
31 *insurance that covers all of the payment for the 20-percent*
32 *coinsurance.*

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

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

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

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

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

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

23 (i) The organization offering the plan substantially violated a
24 material provision of the organization's contract under this article
25 in relation to the individual, including the failure to provide on a
26 timely basis medically necessary care for which benefits are
27 available under the plan or the failure to provide the covered care
28 in accordance with applicable quality standards.

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

32 (F) The individual meets other exceptional conditions as the
33 secretary may provide.

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

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

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

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

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

6 (iii) An organization under an agreement under Section
7 1833(a)(1)(A) of the Social Security Act (health care prepayment
8 plan).

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

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

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

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

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

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

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

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

34 (B) The subsequent enrollment under subparagraph (A) is
35 terminated by the individual during any period within the first 12
36 months of the subsequent enrollment (during which the enrollee
37 is permitted to terminate the subsequent enrollment under Section
38 1851(e) of the federal Social Security Act).

39 (7) The individual upon first becoming eligible for benefits
40 under Medicare Part A at 65 years of age, enrolls in a Medicare

1 Advantage plan under Medicare Part C or with a PACE provider
2 under Section 1894 of the Social Security Act, and disenrolls from
3 the plan or program not later than 12 months after the effective
4 date of enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement

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

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

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

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

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

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

38 (2) At the time of an event described in subdivision (b) by which
39 an individual ceases enrollment under a contract or agreement,
40 policy, or plan, the organization that offers the contract or

1 agreement, regardless of the basis for the cessation of enrollment,
2 the issuer offering the policy or contract, or the administrator of
3 the plan, respectively, shall notify the individual of his or her rights
4 under this section, and of the obligations of issuers of Medicare
5 supplement contracts under subdivision (a). The notice shall be
6 communicated within 10 working days of the date the issuer
7 received notification of disenrollment.

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

11 SEC. 9. Section 1358.13 of the Health and Safety Code is
12 amended to read:

13 1358.13. (a) An issuer shall comply with Section 1882(c)(3)
14 of the federal Social Security Act (as enacted by Section
15 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
16 of 1987 (OBRA), Public Law 100-203) by doing all of the
17 following:

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

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

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

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

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

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

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

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

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

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

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

(2) An issuer shall not in any way reduce or eliminate any benefit or coverage under a Medicare supplement contract at any time after the date of entering the contract, including dates of reinstatement or renewal, unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits. The issuer shall not increase benefits or coverage with a concomitant increase in prepaid or periodic charges during the term of the contract unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee

1 or unless the increased benefits or coverage is required by law or
2 regulation.

3 (c) Medicare supplement contracts shall not provide for the
4 payment of benefits based on standards described as “usual and
5 customary,” “reasonable and customary,” or words of similar
6 import.

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

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

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

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

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

1 issuers shall deliver the guide to the applicant upon request, but
2 not later than at the time the contract is delivered.

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

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

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

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

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

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

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

31
32 “NOTICE: Read this outline of coverage carefully. It is not
33 identical to the outline of coverage provided upon application and
34 the coverage originally applied for has not been issued.”

35
36 (2) The outline of coverage provided to applicants pursuant to
37 this section consists of four parts: a cover page, information about
38 prepaid or periodic charges, disclosure pages, and charts displaying
39 the features of each benefit plan offered by the issuer. The outline
40 of coverage shall be in the language and format prescribed below

1 in no less than 12-point type. All Medicare supplement plans
2 authorized by federal law shall be shown on the cover page, and
3 the plans that are offered by the issuer shall be prominently
4 identified. Information about prepaid or periodic charges for plans
5 that are offered shall be shown on the cover page or immediately
6 following the cover page and shall be prominently displayed. The
7 charge and mode shall be stated for all plans that are offered to
8 the prospective applicant. All possible charges for the prospective
9 applicant shall be illustrated.

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

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

17 (ii) The cover page shall contain the ~~12-plan~~ 14-plan (A-L)
18 charts. The plans offered by the issuer shall be clearly identified.
19 Innovative benefits shall be explained in a manner approved by
20 the director.

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

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

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

33 The text shall read: "Medicare supplement contracts can be sold
34 in only standard plans. This chart shows the benefits included in
35 each plan. Every insurance company must offer Plan A. Some
36 plans may not be available. Plans E, H, I, and J are no longer
37 available for sale. [This sentence shall not appear after June 1,
38 2011.]"

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

1 INFORMATION ABOUT PREPAID OR PERIODIC
2 CHARGES

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

8
9 DISCLOSURES

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

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

19
20 READ YOUR POLICY VERY CAREFULLY

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

27
28 RIGHT TO RETURN POLICY

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

34
35 POLICY REPLACEMENT

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

NOTICE

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

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

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

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

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

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

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

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

35 SEC. 11. Section 1358.18 of the Health and Safety Code is
36 amended to read:

37 1358.18. In the interest of full and fair disclosure, and to assure
38 the availability of necessary consumer information to potential
39 subscribers or enrollees not possessing a special knowledge of

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

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

13
14 “(Statements)
15

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

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

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

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

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

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

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

21
22 (Questions)
23

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

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

32 To the best of your knowledge,

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

34 Yes_____ No_____

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

36 Yes_____ No_____

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

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

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

Yes_____ No_____

If yes,

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

Yes_____ No_____

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

Yes_____ No_____

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

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

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

Yes_____ No_____

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

Yes_____ No_____

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

Yes_____ No_____

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

Yes_____ No_____

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

Yes_____ No_____

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

Yes_____ No_____

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

Yes_____ No_____

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

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

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

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

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

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

30 (e) The notice required by subdivision (d) for an issuer shall be
31 provided in substantially the following form in no less than
32 12-point type:

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

37
38
39 (Company name and address)
40

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

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

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

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

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

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

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

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

18
19
20 _____
21 (Signature of Solicitor, Solicitor Firm, or Other Representative)
22 [Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

23 _____
24 (Applicant's Signature)

25 _____
26 (Date)

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

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

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

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

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

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

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

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

1 “Notice to buyer: This Medicare supplement contract may not
2 cover all of your medical expenses.”

3
4 (4) Inquire and otherwise make every reasonable effort to
5 identify whether a prospective applicant for a Medicare supplement
6 contract already has health care coverage and the types and
7 amounts of that coverage.

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

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

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

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

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

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

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

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

3 1358.24. This section applies to all contracts that become
4 effective on or after May 21, 2009.

5 (a) In addition to the requirements set forth under Sections
6 1365.5 and 1374.7, an issuer of a Medicare supplement contract
7 shall adhere to the requirements imposed by the federal Genetic
8 Information Nondiscrimination Act of 2008 (Public Law 110-233),
9 as follows:

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

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

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

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

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

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

36 (d) Subdivision (c) shall not be construed to preclude an issuer
37 of a Medicare supplement contract from obtaining and using the
38 results of a genetic test in making a determination regarding
39 payment, as defined for the purposes of applying the regulations
40 promulgated under Part C of Title XI and Section 264 of the Health

1 Insurance Portability and Accountability Act of 1996, as may be
2 revised from time to time, and consistent with subdivision (a).

3 (e) For purposes of carrying out subdivision (d), an issuer of a
4 Medicare supplement contract may request only the minimum
5 amount of information necessary to accomplish the intended
6 purpose.

7 (f) An issuer of a Medicare supplement contract shall not
8 request, require, seek, or purchase genetic information for
9 underwriting purposes.

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

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

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

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

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

32 (3) "Genetic information" means, with respect to any individual,
33 information about the individual's genetic tests, the genetic tests
34 of family members of the individual, and the manifestation of a
35 disease or disorder in family members of the individual. The term
36 includes, with respect to any individual, any request for, or receipt
37 of, genetic services, or participation in clinical research which
38 includes genetic services, by the individual or any family member
39 of the individual. Any reference to genetic information concerning
40 an individual or family member of an individual who is a pregnant

1 woman, includes genetic information of any fetus carried by that
2 pregnant woman, or with respect to an individual or family member
3 utilizing reproductive technology, includes genetic information of
4 any embryo legally held by an individual or family member. The
5 term “genetic information” does not include information about the
6 sex or age of any individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (7) Accidental death insurance.

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

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

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

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

23 10192.4. The following definitions apply for the purposes of
24 this article:

25 (a) "Applicant" means:

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

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

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

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

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

38 (e) "Continuous period of creditable coverage" means the period
39 during which an individual was covered by creditable coverage,

1 if during the period of the coverage the individual had no breaks
2 in coverage greater than 63 days.

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

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

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

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

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

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

22 (F) A state health benefits risk pool.

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

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

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

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

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

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

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

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

- 1 (C) Liability insurance, including general liability insurance
2 and automobile liability insurance.
- 3 (D) Workers' compensation or similar insurance.
- 4 (E) Automobile medical payment insurance.
- 5 (F) Credit-only insurance.
- 6 (G) Coverage for onsite medical clinics.
- 7 (H) Other similar insurance coverage, specified in federal
8 regulations, under which benefits for medical care are secondary
9 or incidental to other insurance benefits.
- 10 (3) "Creditable coverage" shall not include the following
11 benefits if they are provided under a separate policy, certificate,
12 or contract of insurance or are otherwise not an integral part of the
13 plan:
- 14 (A) Limited scope dental or vision benefits.
- 15 (B) Benefits for long-term care, nursing home care, home health
16 care, community-based care, or any combination thereof.
- 17 (C) Other similar, limited benefits as are specified in federal
18 regulations.
- 19 (4) "Creditable coverage" shall not include the following
20 benefits if offered as independent, noncoordinated benefits:
- 21 (A) Coverage only for a specified disease or illness.
- 22 (B) Hospital indemnity or other fixed indemnity insurance.
- 23 (5) "Creditable coverage" shall not include the following if
24 offered as a separate policy, certificate, or contract of insurance:
- 25 (A) Medicare supplemental health insurance as defined under
26 Section 1882(g)(1) of the federal Social Security Act.
- 27 (B) Coverage supplemental to the coverage provided under
28 Chapter 55 of Title 10 of the United States Code.
- 29 (C) Similar supplemental coverage provided to coverage under
30 a group health plan.
- 31 (g) "Employee welfare benefit plan" means a plan, fund, or
32 program of employee benefits as defined in Section 1002 of Title
33 29 of the United States Code (Employee Retirement Income
34 Security Act).
- 35 (h) "Insolvency" means when an issuer, licensed to transact the
36 business of insurance in this state, has had a final order of
37 liquidation entered against it with a finding of insolvency by a
38 court of competent jurisdiction in the issuer's state of domicile.
- 39 (i) "Issuer" includes insurance companies, fraternal benefit
40 societies, and any other entity delivering, or issuing for delivery,

1 Medicare supplement policies or certificates in this state, except
2 entities subject to Article 3.5 (commencing with Section 1358) of
3 Chapter 2.2 of Division 2 of the Health and Safety Code.

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

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

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

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

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

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

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

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

36 (o) “1990 standardized Medicare supplement benefit plan,”
37 “1990 standardized benefit plan,” or “1990 plan” means a group
38 or individual policy of Medicare supplement insurance issued on
39 or after July 21, 1992, and with an effective date prior to June 1,
40 2010, and includes Medicare supplement insurance policies and

1 certificates renewed on or after that date which are not replaced
2 by the issuer at the request of the insured.

3 (p) “2010 standardized Medicare supplement benefit plan,”
4 “2010 standardized benefit plan,” or “2010 plan” means a group
5 or individual policy of Medicare supplement insurance issued with
6 an effective date on or after June 1, 2010.

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

9 SEC. 16. Section 10192.6 of the Insurance Code is amended
10 to read:

11 10192.6. (a) Except for permitted preexisting condition clauses
12 as described in Sections 10192.7, 10192.8, and 10192.81, a policy
13 or certificate shall not be advertised, solicited, or issued for delivery
14 as a Medicare supplement policy if the policy or certificate contains
15 limitations or exclusions on coverage that are more restrictive than
16 those of Medicare.

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

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

23 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of
24 Section 10192.8, a Medicare supplement policy with benefits for
25 outpatient prescription drugs that was issued prior to January 1,
26 2006, shall be renewed for current policyholders, at the option of
27 the policyholder, who do not enroll in Medicare Part D.

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

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

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

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

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

3 10192.8. The following standards are applicable to all Medicare
4 supplement policies or certificates advertised, solicited, or issued
5 for delivery on or after January 1, 2001, and with an effective date
6 prior to June 1, 2010. A policy or certificate shall not be advertised,
7 solicited, or issued for delivery as a Medicare supplement policy
8 or certificate unless it complies with these benefit standards.

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

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

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

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

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

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

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

37 (B) The issuer shall not cancel or nonrenew the policy for any
38 reason other than nonpayment of premium or misrepresentation
39 which is shown by the issuer to be material to the acceptance for

1 coverage. The contestability period for Medicare supplement
2 insurance shall be two years.

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

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

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

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

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

39 (6) Termination of a Medicare supplement policy or certificate
40 shall be without prejudice to any continuous loss that commenced

while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

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

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

(B) Reinstitution of coverages:

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

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

11 (iii) Shall provide for classification of premiums on terms at
12 least as favorable to the policyholder or certificate holder as the
13 premium classification terms that would have applied to the
14 policyholder or certificate holder had the coverage not been
15 suspended.

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

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

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

34 (C) An issuer shall not apply new preexisting condition
35 limitations or a new incontestability period to the new policy for
36 those benefits contained in the exchanged 1990 standardized policy
37 or certificate of the insured, but may apply preexisting condition
38 limitations of no more than six months to any added benefits
39 contained in the new 2010 standardized policy or certificate not
40 contained in the exchanged policy. This ~~subdivision~~ *subparagraph*

1 shall not apply to an applicant who is guaranteed issue under
2 Section 10192.11 or 10192.12.

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

7 (9) A Medicare supplement policy shall not limit coverage
8 exclusively to a single disease or affliction.

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

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

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

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

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

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

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

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

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

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 10192.9.

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. If the insurer limits payment
28 to a limiting charge, the insurer has the burden to establish that
29 amount as the legal limit.

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

37 (6) With respect to the basic outpatient prescription drug benefit,
38 coverage for 50 percent of outpatient prescription drug charges,
39 after a two hundred fifty dollar (\$250) calendar year deductible,
40 to a maximum of one thousand two hundred fifty dollars (\$1,250)

1 in benefits received by the insured per calendar year, to the extent
2 not covered by Medicare. On and after January 1, 2006, no
3 Medicare supplement policy may be sold or issued if it includes
4 a prescription drug benefit.

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

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

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

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

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

1 (i) Fecal occult blood test.

2 (ii) Mammogram.

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

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

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

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

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

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

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

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

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

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

38 (iii) Coverage is limited to the following:

39 (I) No more than the number and type of at-home recovery visits
40 certified as necessary by the insured’s attending physician. The

1 total number of at-home recovery visits shall not exceed the number
2 of Medicare-approved home health care visits under a
3 Medicare-approved home care plan of treatment.

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

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

8 (IV) Seven visits in any one week.

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

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

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

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

18 (C) Coverage is excluded for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) With respect to the Medicare Part A deductible, coverage for 75 percent of the Medicare Part A inpatient hospital deductible

1 amount per benefit period until the out-of-pocket limitation
2 described in paragraph (8) is met.

3 (3) With respect to skilled nursing facility care, coverage for
4 75 percent of the coinsurance amount for each day used from the
5 21st day to the 100th day, inclusive, in a Medicare benefit period
6 for posthospital skilled nursing facility care eligible under Medicare
7 Part A until the out-of-pocket limitation described in paragraph
8 (8) is met.

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

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

17 (6) Except for coverage provided in paragraph (7), coverage for
18 75 percent of the cost sharing otherwise applicable under Medicare
19 Part B after the policyholder pays the Part B deductible until the
20 out-of-pocket limitation described in paragraph (8) is met.

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

24 (8) Coverage of 100 percent of the cost sharing for Medicare
25 Parts A and B for the balance of the calendar year after the
26 individual has reached the out-of-pocket limitation on annual
27 expenditures under Medicare Parts A and B of two thousand dollars
28 (\$2,000) in 2006, indexed each year by the appropriate inflation
29 adjustment specified by the secretary.

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

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

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

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

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

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

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

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

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

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

3 (B) The issuer shall not cancel or nonrenew the policy for any
4 reason other than nonpayment of premium or material
5 misrepresentation which is shown by the issuer to be material to
6 the acceptance for coverage. The contestability period for Medicare
7 supplement insurance shall be two years, pursuant to Section
8 10350.2.

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

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

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

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

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

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

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

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

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

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

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

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

1 coverage within 90 days after the date of the loss and pays the
2 applicable premium.

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

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

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

9 (iii) Provide for classification of premiums on terms at least as
10 favorable to the policyholder or certificate holder as the premium
11 classification terms that would have applied to the policyholder
12 or certificate holder had the coverage not been suspended.

13 (8) A Medicare supplement policy shall not limit coverage
14 exclusively to a single disease or affliction.

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

19 (b) With respect to the standards for basic (core) benefits for
20 benefit plans A, B, C, D, F, high deductible F, G, M, and N, every
21 issuer of Medicare supplement insurance benefit plans shall make
22 available a policy or certificate including only the following basic
23 “core” package of benefits to each prospective insured. An issuer
24 may make available to prospective insureds any of the other
25 Medicare Supplement Insurance Benefit Plans in addition to the
26 basic (core) package, but not in lieu of it. However, the benefits
27 described in paragraphs ~~(6) and (7)~~ (7) and (8) shall not be offered
28 so long as California is required to disallow these benefits for
29 Medicare beneficiaries by the centers for Medicare and Medicaid
30 Services or other agent of the federal government under Section
31 1395ss of Title 42 of the 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 through the 90th day, inclusive, in any Medicare benefit
35 period.

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

39 (3) Upon exhaustion of the Medicare hospital inpatient coverage,
40 including the lifetime reserve days, coverage of 100 percent of the

1 Medicare Part A eligible expenses for hospitalization paid at the
2 applicable prospective payment system (PPS) rate, or other
3 appropriate Medicare standard of payment, subject to a lifetime
4 maximum benefit of an additional 365 days. The provider shall
5 accept the issuer's payment as payment in full and may not bill
6 the insured for any balance.

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

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

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

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

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

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

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

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

34 (3) With respect to skilled nursing facility care, coverage for
35 the actual billed charges up to the coinsurance amount from the
36 21st day through the 100th day in a Medicare benefit period for
37 posthospital skilled nursing facility care eligible under Medicare
38 Part A.

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

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

9 (6) 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 \$250,
17 and a lifetime maximum benefit of \$50,000. For purposes of this
18 benefit, “emergency care” shall mean care needed immediately
19 because of an injury or an illness of sudden and unexpected onset.

20 SEC. 19. Section 10192.9 of the Insurance Code is amended
21 to read:

22 10192.9. The following standards are applicable to all Medicare
23 supplement policies or certificates delivered or issued for delivery
24 in this state on or after July 1, 1992, and with an effective date
25 prior to June 1, 2010.

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

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

34 (c) Benefit plans shall be uniform in structure, language,
35 designation and format to the standard benefit plans A to ~~J~~ L,
36 inclusive, listed in subdivision (e), and shall conform to the
37 definitions in Section 10192.4. Each benefit shall be structured in
38 accordance with the format provided in subdivisions (b), (c), (d),
39 and (e) of Section 10192.8 and list the benefits in the order listed
40 in subdivision (e). For purposes of this section, “structure,

1 language, and format” means style, arrangement, and overall
2 content of a benefit.

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

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

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

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

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

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

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

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

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

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

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

(10) Standardized Medicare supplement benefit plan I shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs (1), (2),

(5), (6), (8), and (10) of subdivision (c) of Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

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

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

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

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

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

17 SEC. 20. Section 10192.91 is added to the Insurance Code, to
18 read:

19 10192.91. The following standards are applicable to all
20 Medicare supplement policies or certificates delivered or issued
21 for delivery in this state with an effective date on or after June 1,
22 2010. No policy or certificate may be advertised, solicited,
23 delivered, or issued for delivery in this state as a Medicare
24 supplement policy or certificate unless it complies with these
25 benefit plan standards. Benefit plan standards applicable to
26 Medicare supplement policies and certificates issued with an
27 effective date before June 1, 2010, remain subject to the
28 requirements of Section 10192.9.

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

33 (2) If an issuer makes available any of the additional benefits
34 described in subdivision (c) of Section 10192.81, or offers
35 standardized benefit plans K or L, as described in paragraphs (8)
36 and (9) of subdivision (e), then the issuer shall make available to
37 each prospective policyholder and certificate holder, in addition
38 to a policy form or certificate form with only the basic core benefits
39 as described in paragraph (1), a policy form or certificate form
40 containing either standardized benefit plan C, as described in

1 paragraph (3) of subdivision (e), or standardized benefit plan F,
2 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 10192.10.

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 10192.4.
10 Each benefit shall be structured in accordance with the format
11 provided in subdivisions (b) and (c) of Section 10192.81; or, in
12 the case of plan K or L, in paragraph (8) or (9) of subdivision (e)
13 and list the benefits in the order shown in subdivision (e). For
14 purposes of this section, “structure, language, and format” means
15 style, arrangement, and overall content of a benefit.

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

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

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

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

29 (3) Standardized Medicare supplement benefit plan C shall
30 include only the following: the basic (core) benefit as defined in
31 subdivision (b) of Section 10192.81, plus 100 percent of the
32 Medicare Part A deductible, skilled nursing facility care, 100
33 percent of the Medicare Part B deductible, and medically necessary
34 emergency care in a foreign country, as defined in paragraphs (1),
35 (3), (4), and (6) of subdivision (c) of Section 10192.81,
36 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 10192.81, plus 100 percent of the
40 Medicare Part A deductible, skilled nursing facility care, and

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

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

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

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

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

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

1 paragraphs (1), (3), (5), and (6) of subdivision (c) of Section
2 10192.81, 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 policyholder pays the Part B deductible
39 until the out-of-pocket limitation is met as described in
40 subparagraph (J).

1 (I) Coverage of 100 percent of the cost sharing for Medicare
2 Part B preventive services after the policyholder pays the Part B
3 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 10192.81, plus 50 percent of the
23 Medicare Part A deductible, skilled nursing facility care, and
24 medically necessary emergency care in a foreign country, as
25 defined in paragraphs (2), (3), and (6) of subdivision (c) of Section
26 10192.81, 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 10192.81, 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 10192.81, 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 insured is admitted

1 to any hospital and the emergency visit is subsequently covered
2 as a Medicare Part A expense.

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

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

18 10192.11. (a) (1) An issuer shall not deny or condition the
19 issuance or effectiveness of any Medicare supplement policy or
20 certificate available for sale in this state, nor discriminate in the
21 pricing of a policy or certificate because of the health status, claims
22 experience, receipt of health care, or medical condition of an
23 applicant in the case of an application for a policy or certificate
24 that is submitted prior to or during the six-month period beginning
25 with the first day of the first month in which an individual is both
26 65 years of age or older and is enrolled for benefits under Medicare
27 Part B. Each Medicare supplement policy and certificate currently
28 available from an issuer shall be made available to all applicants
29 who qualify under this subdivision and who are 65 years of age
30 or older.

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

1 Medicare supplement benefit plan K or L shall be made at the
2 issuer's discretion.

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

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

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

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

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

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

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

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

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

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

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

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

38 (h) (1) An individual shall be entitled to an annual open
39 enrollment period lasting 30 days or more, commencing with the
40 individual's birthday, during which time that person may purchase

1 any Medicare supplement policy that offers benefits equal to or
2 lesser than those provided by the previous coverage. During this
3 open enrollment period, no issuer that falls under this provision
4 shall deny or condition the issuance or effectiveness of Medicare
5 supplement coverage, nor discriminate in the pricing of coverage,
6 because of health status, claims experience, receipt of health care,
7 or medical condition of the individual if, at the time of the open
8 enrollment period, the individual is covered under another
9 Medicare supplement policy or contract. An issuer shall notify a
10 policyholder of his or her rights under this subdivision at least 30
11 and no more than 60 days before the beginning of the open
12 enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 (1) *He or she is no longer eligible for Medi-Cal benefits.*

29 (2) *He or she is only eligible for Medi-Cal benefits with a share*
30 *of cost and certifies at the time of application that he or she has*
31 *not met the share of cost.*

32 SEC. 22. Section 10192.12 of the Insurance Code is amended
33 to read:

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

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

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

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

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

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

13 (1) The individual is enrolled under an employee welfare benefit
14 plan that provides health benefits that supplement the benefits
15 under Medicare, ~~the Medicare~~ and either of the following apply:

16 (A) The plan either terminates or ceases to provide all of those
17 supplemental health benefits to the individual, and the individual.

18 (B) The employer no longer provides the individual with
19 insurance that covers all of the payment for the 20-percent
20 coinsurance.

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

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

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

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

37 (D) The Medicare Advantage plan in which the individual is
38 enrolled reduces any of its benefits or increases the amount of cost
39 sharing or discontinues for other than good cause relating to quality
40 of care, its relationship or contract under the plan with a provider

1 who is currently furnishing services to the individual. An individual
2 shall be eligible under this subparagraph for a Medicare supplement
3 policy issued by the same issuer through which the individual was
4 enrolled at the time the reduction, increase, or discontinuance
5 described above occurs or, commencing January 1, 2007, for one
6 issued by a subsidiary of the parent company of that issuer or by
7 a network that contracts with the parent company of that issuer.

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

10 (i) The organization offering the plan substantially violated a
11 material provision of the organization's contract under this article
12 in relation to the individual, including the failure to provide on a
13 timely basis medically necessary care for which benefits are
14 available under the plan or the failure to provide the covered care
15 in accordance with applicable quality standards.

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

19 (F) The individual meets other exceptional conditions as the
20 secretary may provide.

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

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

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

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

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

33 (iii) An organization under an agreement under Section
34 1833(a)(1)(A) of the Social Security Act (health care prepayment
35 plan).

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

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

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

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

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

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

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

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

22 (B) The subsequent enrollment under subparagraph (A) is
23 terminated by the individual during any period within the first 12
24 months of the subsequent enrollment (during which the enrollee
25 is permitted to terminate the subsequent enrollment under Section
26 1851(e) of the federal Social Security Act).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (B) On and after January 1, 2006, an eligible individual
38 described in this paragraph who was most recently enrolled in a
39 Medicare supplement policy with an outpatient prescription drug
40 benefit, is entitled to a Medicare supplement policy that is available

1 from the same issuer but without an outpatient prescription drug
2 benefit or, at the election of the individual, has a benefit package
3 classified as a Plan A, B, C, F (including high deductible Plan F),
4 K, or L that is offered by any issuer.

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

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

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

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

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

37 SEC. 23. Section 10192.13 of the Insurance Code is amended
38 to read:

39 10192.13. (a) An issuer shall comply with Section 1882(c)(3)
40 of the federal Social Security Act (as enacted by Section

1 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act
2 of 1987 (OBRA), Public Law 100-203) by doing all of the
3 following and by certifying compliance on the Medicare
4 supplement insurance experience reporting form:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (j) (1) Issuers shall provide an outline of coverage to all
23 applicants at the time application is presented to the prospective
24 applicant and, except for direct response policies, shall obtain an
25 acknowledgment of receipt of the outline from the applicant. If an
26 outline of coverage is provided at the time of application and the
27 Medicare supplement policy or certificate is issued on a basis
28 which would require revision of the outline, a substitute outline
29 of coverage properly describing the policy or certificate shall
30 accompany the policy or certificate when it is delivered and contain
31 the following statement, in no less than 12-point type, immediately
32 above the company 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 (2) The outline of coverage provided to applicants pursuant to
39 this section consists of four parts: a cover page, premium
40 information, disclosure pages, and charts displaying the features

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

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

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

32
33 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE
34 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible
35 for Medicare, review the Guide to Health Insurance for People
36 with Medicare available from the company.”
37

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

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

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

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

18 (2) If an outline of coverage is provided at or before the time
19 of application and the Medicare supplement policy or certificate
20 is issued on a basis that would require revision of the outline, a
21 substitute outline of coverage properly describing the policy or
22 certificate shall accompany the policy or certificate when it is
23 delivered and contain the following statement, in no less than
24 12-point type, immediately above the name:

25
26 “NOTICE: Read this outline of coverage carefully. It is not
27 identical to the outline of coverage provided upon application and
28 the coverage originally applied for has not been issued.”
29

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

35 (A) (i) The following shall only apply to policies 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~~ 14-plan (A-L)
4 charts. The plans offered by the insurer shall be clearly identified.
5 Innovative benefits shall be explained in a manner approved by
6 the commissioner. The text shall read:

7
8 “Medicare supplement insurance can be sold in only 12 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.

12 The BASIC BENEFITS included in ALL plans are:

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

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

17 Blood: First three pints of blood each year.

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

20 Cervical cancer test: One annual screening.”

21
22 [Reference to the mammogram and cervical cancer screening
23 test shall not be included so long as California is required to
24 disallow them for Medicare beneficiaries by the Centers for
25 Medicare and Medicaid Services or other agent of the federal
26 government under 42 U.S.C. Sec. 1395ss.]

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

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

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

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

6 The BASIC BENEFITS included in ALL plans are:

7 Hospitalization: Medicare Part A coinsurance plus coverage for
8 365 additional days after Medicare benefits end.

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

13 Blood: First three pints of blood each year.

14 Hospice: Part A coinsurance.

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

17 Cervical cancer test: One annual screening.”

18
19 [Reference to the mammogram and cervical cancer screening
20 test shall not be included so long as California is required to
21 disallow them for Medicare beneficiaries by the Centers for
22 Medicare and Medicaid Services or other agent of the federal
23 government under 42 U.S.C. Sec. 1395ss.]

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

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

37 (D) READ YOUR POLICY VERY CAREFULLY. The text
38 shall state: “This is only an outline describing your policy’s most
39 important features. The policy is your insurance contract. You

1 must read the policy itself to understand all of the rights and duties
2 of both you and your insurance company.”

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

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

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

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

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

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

39 (I) One chart for each benefit plan offered by the insurer
40 showing the services, Medicare payments, payments under the

1 policy and payments expected from the insured, using the same
2 uniform format and language. No more than four plans may be
3 shown on one page. Include an explanation of any innovative
4 benefits in a manner approved by the commissioner.

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

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

10 10192.18. (a) Application forms shall include the following
11 questions designed to elicit information as to whether, as of the
12 date of the application, the applicant currently has Medicare
13 supplement, Medicare Advantage, Medi-Cal coverage, or another
14 health insurance policy or certificate in force or whether a Medicare
15 supplement policy or certificate is intended to replace any other
16 disability policy or certificate presently in force. A supplementary
17 application or other form to be signed by the applicant and agent
18 containing those questions and statements may be used.

19
20 (Statements)
21

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

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

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

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

substantially equivalent to your coverage before the date of the suspension.

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

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

(Questions)

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

- 1 [Please mark Yes or No below with an “X.”]
2 To the best of your knowledge,
3 (1) (a) Did you turn 65 years of age in the last 6 months
4 Yes_____ No_____
5 (b) Did you enroll in Medicare Part B in the last 6 months
6 Yes_____ No_____
7 (c) If yes, what is the effective date _____
8 (2) Are you covered for medical assistance through California’s
9 Medi-Cal program
10 NOTE TO APPLICANT: If you have a share of cost under the
11 Medi-Cal program, please answer NO to this question.
12 Yes_____ No_____
13 If yes,
14 (a) Will Medi-Cal pay your premiums for this Medicare
15 supplement policy
16 Yes_____ No_____
17 (b) Do you receive benefits from Medi-Cal OTHER THAN
18 payments toward your Medicare Part B premium
19 Yes_____ No_____
20 (3) (a) If you had coverage from any Medicare plan other than
21 original Medicare within the past 63 days (for example, a Medicare
22 Advantage plan or a Medicare HMO or PPO), fill in your start and
23 end dates below. If you are still covered under this plan, leave
24 “END” blank.
25 START __/__/__ END __/__/__
26 (b) If you are still covered under the Medicare plan, do you
27 intend to replace your current coverage with this new Medicare
28 supplement policy
29 Yes_____ No_____
30 (c) Was this your first time in this type of Medicare plan
31 Yes_____ No_____
32 (d) Did you drop a Medicare supplement policy to enroll in the
33 Medicare plan
34 Yes_____ No_____
35 (4) (a) Do you have another Medicare supplement policy in
36 force
37 Yes_____ No_____
38 (b) If so, with what company, and what plan do you have
39 [optional for direct mailers]
40 Yes_____ No_____

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

3 Yes____ No____

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

7 Yes____ No____

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

9 _____
10 _____
11 _____
12 _____

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

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

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

17
18 (b) Agents shall list any other health insurance policies they
19 have sold to the applicant as follows:

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

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

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

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

39 (e) The notice required by subdivision (d) for an issuer shall be
40 in the form specified by the commissioner, using, to the extent

1 practicable, a model notice prepared by the National Association
2 of Insurance Commissioners for this purpose. The replacement
3 notice shall be printed in no less than 12-point type in substantially
4 the following form:

5
6 [Insurer's name and address]
7

8 NOTICE TO APPLICANT REGARDING REPLACEMENT
9 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
10 ADVANTAGE
11

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

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

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

25 If you want to discuss buying Medicare supplement or Medicare
26 Advantage coverage with a trained insurance counselor, call the
27 California Department of Insurance's toll-free telephone number
28 1-800-927-HELP, and ask how to contact your local Health
29 Insurance Counseling and Advocacy Program (HICAP) office.
30 HICAP is a service provided free of charge by the State of
31 California.

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

1 ___ Additional benefits that are: _____
2 ___ No change in benefits, but lower premiums.
3 ___ Fewer benefits and lower premiums.
4 ___ Plan has outpatient prescription drug coverage and applicant
5 is enrolled in Medicare Part D.

6 ___ Disenrollment from a Medicare Advantage plan. Reasons for
7 disenrollment:

8 ___ Other reasons specified here: _____

9 1. Note: If the issuer of the Medicare supplement policy being
10 applied for does not impose, or is otherwise prohibited from
11 imposing, preexisting condition limitations, please skip to statement
12 3 below. Health conditions that you may presently have
13 (preexisting conditions) may not be immediately or fully covered
14 under the new policy. This could result in denial or delay of a claim
15 for benefits under the new policy, whereas a similar claim might
16 have been payable under your present policy.

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

24 3. If you still wish to terminate your present policy and replace
25 it with new coverage, be certain to truthfully and completely
26 answer any and all questions on the application concerning your
27 medical and health history. Failure to include all material medical
28 information on an application requesting that information may
29 provide a basis for the insurer to deny any future claims and to
30 refund your premium as though your policy had never been in
31 force. After the application has been completed and before you
32 sign it, review it carefully to be certain that all information has
33 been properly recorded. [If the policy or certificate is guaranteed
34 issue, this paragraph need not appear.]

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

38
39
40 _____
 (Signature of Agent, Broker, or Other Representative)

1 _____
2 (Signature of Applicant)
3 _____

4 _____
5 (Date)
6 _____

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

12 (g) An issuer shall not require, request, or obtain health
13 information as part of the application process for an applicant who
14 is eligible for guaranteed issuance of, or open enrollment for, any
15 Medicare supplement coverage pursuant to Section 10192.11 or
16 10192.12, except for purposes of paragraph (1) or (2) of subdivision
17 (a) of Section 10192.11 when the applicant is first enrolled in
18 Medicare Part B. The application form shall include a clear and
19 conspicuous statement that the applicant is not required to provide
20 health information during a period where guaranteed issue or open
21 enrollment applies, as specified in Section 10192.11 or 10192.12,
22 except for purposes of paragraph (1) or (2) of subdivision (a) of
23 Section 10192.11 when the applicant is first enrolled in Medicare
24 Part B, and shall inform the applicant of those periods of
25 guaranteed issuance of Medicare supplement coverage. This
26 subdivision shall not prohibit an issuer from requiring proof of
27 eligibility for a guaranteed issuance of Medicare supplement
28 coverage.

29 SEC. 26. Section 10192.20 of the Insurance Code is amended
30 to read:

31 10192.20. (a) An issuer, directly or through its producers, shall
32 do each of the following:

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

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

38 (3) Display prominently by type, stamp, or other appropriate
39 means, on the first page of the policy, the following:
40

1 “Notice to buyer: This policy may not cover all of your medical
2 expenses.”

3
4 (4) Inquire and otherwise make every reasonable effort to
5 identify whether a prospective applicant for a Medicare supplement
6 policy already has health insurance and the types and amounts of
7 that insurance.

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

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

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

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

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

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

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

38 (1) (A) For policies sold for effective dates prior to June 1,
39 2010, a listing of all the policies, plans A to L, inclusive, that are
40 available from the company.

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

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

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

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

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

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

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

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

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

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

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

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

1 Department of Insurance's Internet Web site
2 (www.insurance.ca.gov)."

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

5 10192.24. This section applies to all policies with policy years
6 beginning on or after May 21, 2009.

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

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

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

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

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

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

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

36 (d) Subdivision (c) shall not be construed to preclude an issuer
37 of a Medicare supplement policy or certificate from obtaining and
38 using the results of a genetic test in making a determination
39 regarding payment, as defined for the purposes of applying the
40 regulations promulgated under Part C of Title XI and Section 264

1 of the Health Insurance Portability and Accountability Act of 1996,
2 as may be revised from time to time, and consistent with
3 subdivision (a).

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

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

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

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

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

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

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

33 (3) "Genetic information" means, with respect to any individual,
34 information about the individual's genetic tests, the genetic tests
35 of family members of the individual, and the manifestation of a
36 disease or disorder in family members of the individual. The term
37 includes, with respect to any individual, any request for, or receipt
38 of, genetic services, or participation in clinical research that
39 includes genetic services, by the individual or any family member
40 of the individual. Any reference to genetic information concerning

1 an individual or family member of an individual who is a pregnant
2 woman includes genetic information of any fetus carried by that
3 pregnant woman, or with respect to an individual or family member
4 utilizing reproductive technology, includes genetic information of
5 any embryo legally held by an individual or family member. The
6 term “genetic information” does not include information about the
7 sex or age of any individual.

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

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

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

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

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

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

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

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

38 SEC. 29. This act is an urgency statute necessary for the
39 immediate preservation of the public peace, health, or safety within

1 the meaning of Article IV of the Constitution and shall go into
2 immediate effect. The facts constituting the necessity are:
3 In order to make the changes required by the federal Medicare
4 Improvements for Patients and Providers Act of 2008 and the
5 federal Genetic Information Nondiscrimination Act of 2008 by
6 the dates imposed under those acts, it is necessary that this act take
7 effect immediately.

O