SB-784 Medicare supplement benefit coverage. (2019-2020)

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Senate Bill No. 784

CHAPTER 157

An act to amend Sections 1358.91 and 1358.11 of, and to add Section 1358.92 to, the Health and Safety Code, and to amend Sections 10192.91, 10192.11, 10192.17, and 10192.20 of, and to add Section 10192.92 to, the Insurance Code, relating to Medicare, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor July 30, 2019. Filed with Secretary of State July 30, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

SB 784, Committee on Health. Medicare supplement benefit coverage.

Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, 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 provides for the issuance of Medicare supplement policies or certificates, as defined, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Existing law requires supplement benefit plans to be uniform in structure, language, designation, and format to specified standard benefit plans, including plans C, F, and high deductible F, which, among other things, cover 100% of the Medicare Part B deductible, and plans D, G, and high deductible G. Existing federal law prohibits, on or after January 1, 2020, the sale of a Medicare supplemental policy that provides coverage of the Medicare Part B deductible to a newly eligible beneficiary.

This bill would, for policies or certificates sold or issued on or after January 1, 2020, to newly eligible Medicare beneficiaries, redesignate standardized Medicare supplement benefit plans C, F, and high deductible F as plans D, G, and high deductible G, respectively, for purposes of conforming state law to federal law. The bill would require standardized Medicare supplement benefit plans D, G, and high deductible G to provide the same coverage as required for plans C, F, and high deductible F, respectively, with the exception of coverage of 100%, or any portion, of the Medicare Part B deductible. The bill would prohibit the sale of standardized Medicare supplement benefit plans C, F, and high deductible F to newly eligible beneficiaries. The bill would define a newly eligible beneficiary as an individual who becomes eligible for Medicare on or after January 1, 2020, because the individual attained 65 years of age on or after January 1, 2020, or the individual became eligible for Medicare benefits on or after January 1, 2020, by reason of disability, as specified. The bill would make related conforming changes. Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

This bill would declare that it is to take effect immediately as an urgency statute.
Vote: 2/3 Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1358.91 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

(4) Standardized Medicare supplement benefit plan D shall include only the following: the basic (core) benefit, as defined in subdivision (b) of Section 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.

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

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

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

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

(B) Effective January 1, 2020, the standardized benefit plans described in paragraph (4) of subdivision (a) of Section 1358.92 (redesignated high deductible plan G) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) Standardized Medicare supplement 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. 2. Section 1358.92 is added to the Health and Safety Code, immediately following Section 1358.91, to read:

1358.92. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in the state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 1358.91 or 1358.9, as applicable.

(a) The standards and requirements of Section 1358.91 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit plan C is redesignated as plan D and shall provide the benefits described in paragraph (3) of subdivision (e) of Section 1358.91 but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit plan F is redesignated as plan G and shall provide the benefits described in paragraph (5) of subdivision (e) of Section 1358.91, but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and high deductible plan F may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit high deductible plan F is redesignated as high deductible plan G and shall provide the benefits described for standardized Medicare supplement benefit high deductible plan F in paragraph (6) of subdivision (e) of Section 1358.91, but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible. The Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual deductible under high deductible plan G.

(5) The reference to standardized Medicare supplement benefit plan C or F in paragraph (2) of subdivision (a) of Section 1358.91 shall, for purposes of this section, be deemed a reference to standardized Medicare supplement benefit plan D or G, respectively.

(b) This section shall apply only to individuals who are newly eligible for Medicare on or after January 1, 2020. For purposes of this section, “newly eligible Medicare beneficiary” means an individual who satisfies one of the following:

(1) The individual has attained 65 years of age on or after January 1, 2020.

(2) The individual is entitled to benefits under Medicare Part A pursuant to Section 226(b) or 226A of the Social Security Act, or is deemed eligible for benefits under Section 226(a) of the Social Security Act, on or after January 1, 2020.

(c) For purposes of subdivision (e) of Section 1358.12, in the case of an individual newly eligible for Medicare on or after January 1, 2020, any reference to standardized Medicare supplement benefit plan C, plan F, or high deductible plan F shall be deemed to be a reference to standardized Medicare supplement benefit plan D, plan G, or high deductible plan G, respectively, that meet the requirements of subdivision (a).

(d) On or after January 1, 2020, the standardized Medicare supplement benefit plans described in paragraph (4) of subdivision (a) may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized Medicare supplement benefit plans described in subdivision (e) of Section 1358.91.

SEC. 3. 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 made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

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

(B) For contracts sold or issued on or after January 1, 2020, to newly eligible Medicare beneficiaries, as defined in subdivision (b) of Section 1358.92, an issuer shall make available Medicare supplement benefit plans A, B, D, and G, if currently available, to applicants who qualify under this subdivision who are 64 years of age or younger and who do not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer’s discretion.

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

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

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

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

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of their enrollment in Medicare Part B, or if notified retroactively of their eligibility for Medicare, for six

months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) A 1990 standardized Medicare supplement benefit 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) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements:

(1) They are no longer eligible for Medi-Cal benefits.

(2) They are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

SEC. 4. Section 10192.91 of the Insurance Code is amended to read:

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

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

(2) If an issuer makes available any of the additional benefits described in subdivision (c) of Section 10192.81, or offers standardized benefit plans K or L, as described in paragraphs (8) and (9) of subdivision (e), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in paragraph (1), a policy form or certificate form containing either standardized benefit plan C, as described in paragraph (3) of subdivision (e), or standardized benefit plan F, as described in paragraph (5) of subdivision (e).

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

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in subdivision (e) and conform to the definitions in Section 10192.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b) and (c) of Section 10192.81; or, in the case of plan K or L, in paragraph (8) or (9) of subdivision (e) and list the benefits in the order shown in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

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

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

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

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

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

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

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

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

(B) Effective January 1, 2020, the standardized benefit plans described in paragraph (4) of subdivision (a) of Section 10192.92 (redesignated high deductible plan G) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 5. Section 10192.92 is added to the Insurance Code, immediately following Section 10192.91, to read:

10192.92. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered, or issued for delivery in the state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 10192.91 or Section 10192.9, as applicable.

(a) The standards and requirements of Section 10192.91 shall apply to all Medicare supplement policies delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit plan C is redesignated as plan D and shall provide the benefits described in paragraph (3) of subdivision (e) of Section 10192.91 but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit plan F is redesignated as plan G and shall provide the benefits described in paragraph (5) of subdivision (e) of Section 10192.91, but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and high deductible plan F may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit high deductible plan F is redesignated as high deductible plan G and shall provide the benefits described for standardized Medicare supplement benefit high deductible plan F in paragraph (6) of subdivision (e) of Section 10192.91, but shall not provide coverage for 100 percent, or any portion, of the Medicare Part B deductible. The Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual deductible under high deductible plan G.

(5) The reference to standardized Medicare supplement benefit plans C or F in paragraph (2) of subdivision (a) of Section 10192.91 shall, for purposes of this section, be deemed a reference to standardized Medicare supplement benefit plan D or G, respectively.

(b) This section shall apply only to individuals who are newly eligible for Medicare on or after January 1, 2020. For purposes of this section, “newly eligible Medicare beneficiary” means an individual who satisfies one of the following:

(1) The individual has attained 65 years of age on or after January 1, 2020.

(2) The individual is entitled to benefits under Medicare Part A pursuant to Section 226(b) or 226A of the Social Security Act, or is deemed eligible for benefits under Section 226(a) of the Social Security Act, on or after January 1, 2020.

(c) For purposes of subdivision (e) of Section 10192.12, in the case of an individual newly eligible for Medicare on or after January 1, 2020, any reference to standardized Medicare supplement benefit plan C, plan F, or high deductible plan F shall be deemed to be a reference to standardized Medicare supplement benefit plan D, plan G, or high deductible plan G, respectively, that meet the requirements of subdivision (a).

(d) On or after January 1, 2020, the standardized Medicare supplement benefit plans described in paragraph (4) of subdivision (a) may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized Medicare supplement benefit plans described in subdivision (e) of Section 10192.91.

SEC. 6. Section 10192.11 of the Insurance Code is amended to read:

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

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

(B) For policies sold on or after January 1, 2020, to newly eligible Medicare beneficiaries, as defined in subdivision (b) of Section 10192.92, an issuer shall make available Medicare supplement benefit plans A, B, D, and G, if currently available, to applicants who qualify under this subdivision who are 64 years of age or younger and who do not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer’s discretion.

(3) This section and Section 10192.12 do not prohibit an issuer in determining premium rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification. This section shall not be construed

as preventing the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10192.8 or paragraph (1) of subdivision (a) of Section 10192.81.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) A 1990 standardized Medicare supplement benefit 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) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements:

(1) They are no longer eligible for Medi-Cal benefits.

(2) They are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

SEC. 7. 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 and customary," "reasonable and customary," or words of similar import.

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

(e) (1) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, and of the outline of coverage, or attached thereto, in no less than 10-point uppercase type, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate, via regular mail, within 30 days of receiving it, and to have the full premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(II) The cover page shall contain the 14-plan (A-L) charts. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

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

The BASIC BENEFITS included in ALL plans are:

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

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

Blood: First three pints of blood each year.

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

Cervical cancer test: One annual screening."

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

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

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

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

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

The BASIC BENEFITS included in ALL plans are:

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

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

Cervical cancer test: One annual screening."

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

(iii) The following shall apply only to policies sold for effective dates on or after January 1, 2020:

(I) The outline of coverage shall include the items, and in the same order specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2016.

(II) The cover page shall contain all Medicare supplement benefit plan charts A to D, inclusive, F, high deductible F, G, high deductible G, and K to N, inclusive. The plans offered by the insurer shall be clearly identified. Plans C, F, and high deductible F shall be noted as available only to applicants eligible before 2020. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

"Medicare supplement insurance can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A.

The BASIC BENEFITS included in ALL plans are:

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

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

Cervical cancer test: One annual screening."

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 8. Section 10192.20 of the Insurance Code is amended to read:

10192.20. (a) An issuer, directly or through its producers, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of policies by its agents or other producers will be fair and accurate.

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

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

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement policy already has health insurance and the types and amounts of that insurance.

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

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

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

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

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

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

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

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

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

(C) For policies sold or issued for effective dates on or after January 1, 2020, a listing of all the policies, plans A to D, inclusive, F, high deductible F, G, high deductible 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 65 years of age 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, high deductible F, G, and K to N, inclusive, for Medicare beneficiaries under 65 years of age that are available from the company.

(C) For policies sold or issued for effective dates on or after January 1, 2020, a listing of all the policies, plans A to D, inclusive, F, high deductible F, G, high deductible G, and K to N, inclusive, for Medicare beneficiaries under 65 years of age 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 website.

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

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 10. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to provide Medicare beneficiaries with access to Medicare supplement benefit plans to ensure quality of health, it is necessary that this act take effect immediately.