§ 1358.81. General standards for contracts with an effective date on or after June 1, 2010; Core benefits; Additional benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E)(i) If a group Medicare supplement contract is replaced by another group Medicare supplement contract purchased by the same group contractholder, the issuer of the replacement contract shall offer coverage to all persons covered under the old group contract on its

date of termination. Coverage under the new contract shall not result in any exclusion for preexisting conditions that would have been covered under the group contract being replaced.

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

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

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

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

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

date of loss of coverage) if the enrollee or subscriber provides notice of loss of coverage within 90 days after the date of the loss and pays the applicable prepaid or periodic charge.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Coverage of Part A Medicare eligible expenses for hospitalization to

the extent not covered by Medicare from the 61st day through the 90th day, inclusive, in any Medicare benefit period.

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

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

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

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

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

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

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

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

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

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

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

(6) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive

days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

HISTORY:

Added Stats 2009 ch 10 § 4 (AB 1543), effective July 2, 2009.