§ 1358.10. Medicare Select contracts

(a)(1) This section shall apply to Medicare Select contracts, as defined in this section.

(2) A contract shall not be advertised as a Medicare Select contract unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual covered by a Medicare Select contract with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select contract.

(4) "Medicare Select contract" means a Medicare supplement contract that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits covered under a Medicare Select contract. "Provider network" means a grouping of network providers.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select contract.

(c) The director may authorize an issuer to offer a Medicare Select contract pursuant to Section 4358 of the federal Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer's Medicare Select contracts are in compliance with this chapter and if the director finds that the issuer has satisfied all of the requirements of this section.

(d) A Medicare Select issuer shall not issue a Medicare Select contract in this state until its plan of operation has been approved by the director.

(e) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of all of the following:

(A) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and afterhour care. The hours of operation and availability of afterhour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) That the number of network providers in the service area is sufficient, with respect to current and expected enrollees, as to either of the following:

(i) To deliver adequately all services that are subject to a restricted network provision.

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 24 hours per day and seven days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, that there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual covered under a Medicare Select contract.

This subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select contract.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including all of the following:

(A) The formal organizational structure.

(B) The written criteria for selection, retention, and removal of network providers.

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with subdivision (i).

(7) Any other information requested by the director.

(f)(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

(g) A Medicare Select contract shall not restrict payment for covered services provided by nonnetwork providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition.

(2) It is not reasonable to obtain services through a network provider.

(h) A Medicare Select contract shall provide payment for full coverage under the contract for covered services that are not available through network providers.

(i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select contract to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and charges of the Medicare Select contract with both of the following:

(A) Other Medicare supplement contracts offered by the issuer.

(B) Other Medicare Select contracts.

(2) A description, including address, telephone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. The description shall inform the applicant that expenses incurred when using out-of-network providers are excluded from the out-of-pocket annual limit in benefit plans K and L, unless the contract provides otherwise.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the enrollee's rights to purchase any other Medicare supplement contract otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(j) Prior to the sale of a Medicare Select contract, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subdivision (i) and that the applicant understands the restrictions of the Medicare Select contract.

(k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the enrollees. The proce-

dures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the contract and in the outline of coverage.

(2) At the time the contract is issued, the issuer shall provide detailed information to the enrollee describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decisionmakers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select contract the opportunity to purchase any Medicare supplement contract otherwise offered by the issuer.

(m)(1) At the request of an enrollee under a Medicare Select contract, a Medicare Select issuer shall make available to the enrollee the opportunity to purchase a Medicare supplement contract offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision, if a Medicare supplement contract of that nature is offered by the issuer. The issuer shall make the contracts available without regard to the health status of the enrollee and without requiring evidence of insurability after the Medicare Select contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(n) Medicare Select contracts shall provide for continuation of coverage in the event the secretary determines that Medicare Select contracts issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each enrollee covered by a Medicare Select contract the opportunity to purchase any Medicare supplement contract offered by the issuer that has comparable or lesser benefits and that does not contain a restricted provider network provision, if a Medicare supplement contract of that nature is offered by the issuer. The issuer shall make the contracts available without regard to the health status of the enrollee and without requiring evidence of insurability after the Medicare Select contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains

one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(o) An issuer offering Medicare Select contracts shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program. An issuer shall not issue a Medicare Select contract in this state until the contract has been approved by the director.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764).
Amended Stats 2005 ch 206 § 6 (SB 375).

§ 1358.11. Discriminatory practices; Age; Time periods; Open enroll- ment periods; Standardized Medicare supplement benefit plan offer- ings

(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) does not prevent 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 60 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, an issuer that falls under this paragraph shall not 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, and on any notice related to a benefit modification or premium adjustment.

(2) For purposes of this subdivision, the following provisions 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.

(M) New or innovative benefits, as described in subdivision (f) of Section 1358.9 and subdivision (f) of Section 1358.91, shall not be included when determining whether benefits are equal to or lesser than those provided by the previous coverage.

(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.

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2000 ch 707 § 1 (SB 1814), effective September 27, 2000, operative January 1, 2001; Stats 2001 ch 159 § 125 (SB 662); Stats 2002 ch 555 § 1 (SB 1531); Stats 2003 ch 13 § 1 (SB 581), effective May 28, 2003; Stats 2005 ch 206 § 7 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 7 (AB 1543), effective July 2, 2009; Stats 2011 ch 270 § 1 (AB 151), effective January 1, 2012; Stats 2019 ch 157 § 3 (SB 784), effective July 30, 2019; Stats 2019 ch 549 § 2 (SB 407), effective January 1, 2020.