§ 1358.8. General standards for contracts with effective date prior to June 1, 2010; Core benefits; Additional benefits to Medicare supplement benefit plans B to L

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

(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 covered person, other than the nonpayment of the prepaid or periodic charge.

(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 the prepaid or periodic charge 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 a group Medicare supplement contract is terminated by the subscriber and is not replaced as provided under subparagraph (E), the issuer shall offer enrollees an individual Medicare supplement contract that, at the option of the enrollee, either provides for continuation of the benefits contained in the terminated contract or provides for benefits that otherwise meet the requirements of this subsection.

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

(E) If a group Medicare supplement contract is replaced by another group Medicare supplement contract purchased by the same subscriber, 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.

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

(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 covered person, limited to the duration of the contract

benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

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

If suspension occurs and if the enrollee loses entitlement to medical assistance, the contract shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the enrollee 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. Upon receipt of timely notice, the issuer shall return directly to the enrollee that portion of the prepaid or periodic charge attributable to the period the enrollee was entitled to medical assistance, subject to adjustment for paid claims.

(ii) A Medicare supplement contract shall provide that benefits and premiums under the contract shall be suspended at the request of the enrollee or subscriber for any period that may be provided by federal regulation 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 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 within 90 days of the date of the loss of coverage.

(B) Reinstitution of coverages:

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

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

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

(8) If an issuer makes a written offer to the Medicare supplement enrollee or subscriber of one or more of its plan contracts, to exchange during a specified period from his or her 1990 standardized plan, as described in Section 1358.9, to a 2010 standardized plan, as described in

Section 1358.91, the offer and subsequent exchange shall comply with the following requirements:

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

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

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

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

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

(10) 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.

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

(12) 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.

(13) 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 to J, inclusive, every issuer shall make available a contract including only the following basic "core" package of benefits to each prospective applicant. This "core" package of benefits shall be referred to as standardized Medicare supplement benefit plan "A". An issuer may make available to prospective applicants 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 to 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 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 enrollee or subscriber 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 services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

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

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

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

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

(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

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

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

(8) 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.

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

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

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

(i) Fecal occult blood test.

(ii) Mammogram.

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

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

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

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

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

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

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

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

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

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

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

(iii) Coverage is limited to the following:

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

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

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

(IV) Seven visits in any one week.

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

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

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

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

(C) Coverage is excluded for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Except for coverage provided in paragraph (7), coverage for 75 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 described in paragraph (8) is met.

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

(8) Coverage of 100 percent of the cost sharing for 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 two thousand dollars ($2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

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

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 4 (SB 375), effective January 1, 2006; Stats 2009 ch 10 § 3 (AB 1543), effective July 2, 2009.