Senate Bill No. 2043

Passed the Senate August 26, 1996

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Secretary of the Senate

Passed the Assembly August 22, 1996

_____

Chief Clerk of the Assembly

This bill was received by the Governor this ___ day

of _____, 1996, at ___ o'clock __M.

_____

Private Secretary of the Governor

CHAPTER ____

An act to amend Sections 1358, 1358.3, 1358.5, 1358.8, 1358.11, 1358.20, and 1373.621 of the Health and Safety Code, to amend Sections 10116.5, 10194.7, 10194.8, 10195.1, 10197, 10197.1, and 10197.6 of the Insurance Code, and to amend Section 2800.2 of the Labor Code, relating to health care coverage and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 2043, Rosenthal. Health care coverage: Medicare supplement coverage.

(1) Existing law requires a health care service plan offering contracts to supplement Medicare, among other things, to establish marketing procedures that set forth a mechanism or formula for determining whether replacement coverage contains benefits clearly and substantially greater than the benefits under the replaced coverage.

This bill would delete that requirement.

(2) Under existing law, no Medicare supplement insurer or health care service plan may 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 an applicant if the application is submitted within 6 months after the applicant, who is 65 years of age or older, first enrolls for benefits under Medicare Part B. Under existing law, willful violation of the law regulating health care service plans is a misdemeanor.

This bill would instead make that provision applicable in the case of an application for a policy or certificate that is submitted prior to or during the 6-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 Medicare benefits, as specified. This bill

would make comparable changes with respect to Medicare supplement insurance.

This provision would also apply to an individual each year during an open enrollment period of 30 days or more commencing with the individual's birthday, if the individual is covered by another Medicare supplement policy or contract at the time of the open enrollment. The bill would require a plan that offers contracts to supplement Medicare and a health care service plan to notify an enrollee or policyholder of his or her rights under this bill. By changing the definition of a crime, the bill would impose a state-mandated local program.

(3) Existing law provides, with respect to a health care service plan offering contracts to supplement Medicare, that if coverage is replaced, no plan shall provide compensation to a solicitor or solicitor firm, and no solicitor or solicitor firm shall receive compensation, in a greater amount than the renewal compensation for the replaced coverage, unless the benefits under the new coverage are clearly and substantially greater than the benefits under the replaced coverage.

This bill would remove the exception to the above provision.

With respect to those plans, existing law also specifies the calculation of actual or expected loss ratios.

This bill would provide that those loss ratios also apply to prestandardized plan contracts and certificates issued prior to July 21, 1992, the date mandated for standardized Medicare supplement coverage, as specified. It would also provide that for contracts issued prior to July 21, 1992, expected claims in relation to premiums must meet specified requirements.

(4) Existing law requires every disability insurance policy issued to persons eligible for Medicare by reason of age that is not a Medicare supplement policy, as specified, to so inform those persons that the policy is not a Medicare supplement policy.

This bill would revise those provisions.

(5) Existing insurance law provides that a Medicare supplement policy or certificate form shall not be issued

unless it can be expected to return to the insured certain aggregate benefits, not including anticipated refunds or credits.

This bill would provide that the provision applies to renewal of a policy or certificate, and would specify that it also applies to prestandardized policies and certificates issued prior to July 21, 1992.

The bill would also provide that mass-marketed policies issued before the effective date of the bill shall be subject to the individual loss ratio.

(6) Existing law provides that if Medicare supplement coverage is replaced, no agent, subagent, or other producer shall receive commission or compensation, and no insurer or other entity shall pay commission or compensation, in a greater amount than the renewal compensation for the original coverage, unless the insurer can show that the benefit to the insured is clearly and substantially greater.

This bill would remove the exception to the above provision.

(7) Existing law requires health care service plan contracts, disability insurance policies, and nonprofit hospital service plan contracts, that provide hospital, medical, or surgical expense coverage under the plan of an employer subject to federal continuing medical insurance requirements, known as "COBRA," to permit an employer to provide extended coverage to eligible former employees and their spouses that would automatically terminate under specified conditions.

This bill would delete nonprofit hospital service plan contracts from this requirement, would add former spouses, as defined, to those provisions, and would change the conditions under which the extended coverage for spouses and former spouses would automatically terminate.

(8) Existing law requires an employer, employee association, or other entity providing continuation coverage to notify a former employee or spouse of the availability of continuation coverage.

This bill would also require those entities to notify former spouses.

(9) 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.

(10) The bill would incorporate additional amendments to Section 10194.7 of the Insurance Code, proposed by SB 1581, contingent upon the prior enactment of that bill.

The bill would declare that it is to take effect immediately as an urgency statute, but certain provisions would become operative January 1, 1997.

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

SECTION 1. Section 1358 of the Health and Safety Code is amended to read:

1358. Every health care service plan that offers any contract that primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, shall, in addition to complying with this chapter and rules of the commissioner, comply with this article. This article shall not apply to a contract or other arrangement of a health care service plan that offers benefits under Section 1395mm of Title 42 of the United States Code or under a demonstration project authorized pursuant to amendments to the federal Social Security Act. This article shall not apply to a contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

As used in this chapter, ''Medicare'' means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, Title 1, Part 1 of Public

Law 89-97, enacted by the 89th United States Congress; as then constituted or as later amended.

SEC. 2. Section 1358.3 of the Health and Safety Code is amended to read:

1358.3. (a) In the interest of full and fair disclosure, and to assure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, and Medicare supplement contracts, a health care service plan offering contracts to supplement Medicare shall comply with the provisions of this section.

(b) The application form for persons eligible for Medicare used by a plan described in subdivision (a) shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or contract in force or whether a Medicare supplement contract is intended to replace any accident and sickness policy or certificate or plan contract presently in force. A supplementary application or other form to be signed by the applicant and solicitor, containing the questions and statements may be used.

[Statements]

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

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

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

(4) The benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or medicaid. If you are no longer entitled to Medi-Cal or

medicaid, your contract will be reinstituted if requested within 90 days of losing Medi-Cal or medicaid eligibility.

(5) Counseling services may be available in your area to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medi-Cal or medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

[Questions]

To the best of your knowledge:

(1) Do you have another Medicare supplement insurance policy or health care service plan contract in force?

(A) If so, with which company?

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

(2) Do you have any other health coverage that provides benefits similar to this Medicare supplement contract ?

(A) If so, with which company?

(B) What kind of coverage?

(3) Are you covered by Medi-Cal or medicaid?

(A) As a specified Low-Income Medicare Beneficiary (SLMB)?

(B) As a Qualified Medicare Beneficiary (QMB)?

(C) For other Medi-Cal or medicaid benefits?

(c) Solicitors shall list any other health insurance policies or plan contracts they have sold to the applicant. The list shall include a list of policies and plan contracts sold that are still in force, and a list of policies and plan contracts sold in the past five years that are no longer in force.

(d) Plans issuing Medicare supplement contracts without a solicitor or solicitor firm shall return to the

applicant, upon delivery of the contract, a copy of the application or supplemental form, signed by the applicant and acknowledged by the plan.

(e) Upon determining that a sale will involve replacement of Medicare supplement coverage, a plan described in subdivision (a), other than a plan selling as a result of direct response solicitation, as described below, or its agent shall furnish the applicant, prior to issuance or delivery of the Medicare supplement contract, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the plan. However, a plan described in subdivision (a) that is selling as a result of direct response solicitation, that is, solicitation through the news media or the mail shall deliver to the applicant at the time of issuance of the contract a notice regarding replacement of Medicare supplement coverage. The notice required by this subdivision shall be provided in substantially the form set forth in subdivision (f).

(f) The notice required by this subdivision shall be provided in substantially the following form in no less than 10-point type:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF MEDICARE SUPPLEMENT
COVERAGE

(Company name and address)

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate an existing Medicare supplement policy or plan contract and replace it with a contract to be issued by [Plan Name]. Your plan contract to be issued by [Plan Name] will provide 30 days within which you may decide without

cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY PLAN, SOLICITOR, SOLICITOR FIRM, OR OTHER REPRESENTATIVE:

(1) I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement contract is being purchased for the following reason (check one):
__ Additional benefits.
__ No change in benefits, but lower premiums.
__ Fewer benefits and lower premiums.
__ Other. (please specify) _____

(2) You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

(4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any

future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

(Signature of Solicitor, Solicitor Firm, or Other Representative)
[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

(Applicant's Signature)

(Date)

(g) Notwithstanding the provisions of this section, a plan shall not be required to comply with the provisions of this section with respect to any group contract that is any of the following:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

(2) A group contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of the contract to its members.

SEC. 3. Section 1358.5 of the Health and Safety Code is amended to read:

1358.5. (a) A health care service plan offering contracts to supplement Medicare shall do all of the following:

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

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

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and plan contract the following: ''Notice to buyer: This plan contract may not cover all of your medical expenses.''

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement coverage already has accident and sickness coverage and the types and amounts of any such coverage.

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

(b) The following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any accident and sickness coverage for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any coverage or to take out coverage with another plan or contract.

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

(3) Cold-lead advertising. 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 solicitation of Medicare supplement coverage and that contact will be made by a health care service plan or its representative.

(c) In recommending the purchase or replacement of any Medicare supplement coverage a plan or its representative shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(d) Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy certificate or contract is prohibited.

SEC. 4. Section 1358.8 of the Health and Safety Code is amended to read:

1358.8. (a) A health care service plan offering contracts to supplement Medicare may provide commission or other compensation to a solicitor or solicitor firm for the sale of a Medicare supplement contract only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the contract in the second year or period.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period, and shall be provided for at least five years.

(c) If coverage is replaced, no plan shall provide compensation to a solicitor or solicitor firm, and no solicitor or solicitor firm shall receive compensation, in a greater amount than the renewal compensation for the replaced coverage.

(d) For purposes of this section, ‘‘commission’’ or ‘‘compensation’’ includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the contract, including, but not limited to, bonuses, gifts, prizes, awards, and finder’s fees.

SEC. 5. Section 1358.11 of the Health and Safety Code is amended to read:

1358.11. (a) No plan subject to this article may advertise, solicit for, enter, or renew any plan contract that primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage unless the contract returns to the subscribers and enrollees in the form of

aggregate benefits under the contract, not including anticipated refunds or credits, as estimated for the entire period for which prepaid or periodic charges are computed to provide coverage, on the basis of incurred claims or costs of health care services experience and earned prepaid or periodic charges for that period and in accordance with accepted actuarial principles and practices:

(1) At least 75 percent of the aggregate amount of prepaid or periodic charges collected in the case of group contracts.

(2) At least 65 percent of the aggregate amount of prepaid or periodic charges collected in the case of individual contracts.

(b) The calculation of actual or expected loss ratios shall be pursuant to that formula, definitions, procedures, and other provisions as may be deemed by the commissioner, with due consideration of the circumstances of the particular plan, to be fair, reasonable, and consistent with the objectives of this chapter. These loss ratios shall also apply to prestandardized plan contracts and certificates issued prior to July 21, 1992, the date mandated for standardized Medicare supplement coverage by the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508).

(c) Each plan subject to subdivision (a) shall submit to the department a copy of the calculations for the actual or expected loss ratio as required by Section 1358.9. The calculations shall include the following data: the actual loss ratio for the entire period in which the plan contract has been in force, as well as for the immediate past three years and for each year in which the plan contract has been in force; the scale of prepaid or periodic charges for the loss ratio calculation period, a description of all assumptions, the formula used to calculate gross prepaid or periodic charges, the expected level of earned prepaid or periodic charges in the loss ratio calculation period, and the expected level of incurred claims for reimbursement, including paid claims and incurred but not paid claims, in the loss ratio calculation period. The

calculations shall be accompanied by an actuarial certification, consisting of a signed declaration of an actuary who is a member in good standing of the American Academy of Actuaries in which the actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account that the calculations are in accordance with the provisions of subdivision (b) and the provisions referred to therein. In addition, the commissioner may require the plan to submit actuarial certification, as described above, by one or more unaffiliated actuaries acceptable to the commissioner.

(d) Notwithstanding the calculations required by subdivision (c), plan contracts shall be deemed to comply with the loss ratio standards if, and shall be deemed not to comply with the loss standards unless: (1) for the most recent year, the ratio of the incurred losses to earned prepaid charges for contracts that have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (2) the expected losses in relation to premiums over the entire period for which the contract is rated comply with the requirements of this section. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

(e) Notwithstanding the provisions of this section, this section shall not apply to any group contract that is either:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations.

(2) A group contract with any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for

purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of the contract to its members.

(f) For contracts issued prior to July 21, 1992, expected claims in relation to premiums shall meet all of the following:

(1) The originally filed anticipated loss ratio when combined with the actual experience since July 21, 1992.

(2) The appropriate percentage from paragraphs (1) and (2) of subdivision (a) when combined with actual expenses on or after the effective date of this act.

(3) The appropriate percentage from paragraphs (1) and (2) of subdivision (a) over the entire future period for which rates are computed to provide coverage on or after the effective date of this act.

SEC. 6. Section 1358.20 of the Health and Safety Code is amended to read:

1358.20. (a) No plan shall deny or condition the offering or effectiveness of any Medicare supplement contract, nor discriminate in the pricing of the 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 that 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 a plan shall be made available to all applicants who qualify under this section. This section 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 subscriber or enrollee received treatment or was otherwise diagnosed during the six months before it became effective.

(b) (1) In determining whether an exclusion of benefits for a preexisting condition may be applied to any person during the open enrollment period provided in this section for Medicare supplement coverage, a plan shall credit the time the person was covered under

qualifying prior coverage, provided the individual becomes eligible for coverage under the Medicare supplement plan:

(A) Within 180 days of the termination of any qualifying prior coverage if the qualifying prior coverage is offered through employment or sponsored by an employer and if the Medicare supplement insurance is offered through succeeding employment or sponsored by a succeeding employer, and is not in violation of the Medicare Secondary Payer provision of Section 1862(b) of the Social Security Act (42 U.S.C. Sec. 1395y(b)).

(B) In cases not covered by paragraph (1), within 30 days of the termination of any other qualifying prior coverage.

(2) For purposes of this section, qualifying prior coverage means any of the following:

(A) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, long-term care insurance, dental coverage, vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(B) The medicaid program pursuant to Title XIX of the Social Security Act.

(C) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care, not including the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) An individual enrolled in Medicare Part B by reason of disability shall be entitled to open enrollment described in this section for six months after he or she reaches age 65. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

(d) An individual who is 65 years of age or older and enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(1) 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. For purposes of this section, ''employer-sponsored retiree health plan'' includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(2) 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.

(e) An individual who is 65 years of age or older and 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.

(f) 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, with the exception of a Medicare Select policy, that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no plan that offers contracts to supplement Medicare 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. A plan that offers contracts to supplement Medicare shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

SEC. 7. Section 1373.621 of the Health and Safety Code is amended to read:

1373.621. (a) Except for a specialized health care service plan, every health care service plan contract that is issued, amended, delivered, or renewed in this state on or after January 1, 1996, that provides hospital, medical, or surgical expense coverage under an employer-sponsored group plan for an employer subject to COBRA, as defined herein, including a carrier providing replacement coverage under Section 1399.63, shall further offer the former employee the opportunity to continue benefits as required under subdivision (b), and shall further offer the former spouse of an employee or former employee the opportunity to continue benefits as required under subdivision (c).

(b) (1) In the event a former employee who worked for the employer for at least five years prior to the date of termination of employment and who is 60 years of age or older on the date employment ends is entitled to and so elects to continue benefits under COBRA for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under COBRA ends, as set forth in paragraph (2). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA had remained in force. For the employee or spouse, continuation coverage following the end of COBRA is subject to payment of premiums to the health care service plan. Individuals ineligible for COBRA are not entitled to continuation coverage under this section.

Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the former employer.

(2) The former employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the plan in writing within 30 calendar days prior to the date continuation coverage under COBRA is scheduled to end.

(3) The continuation coverage shall end automatically on the earlier of (A) the date the individual reaches age 65, (B) the date the individual is covered under any group health plan not maintained by the employer, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) for a spouse, five years from the date on which continuation coverage under COBRA was scheduled to end for the spouse, or (E) the date on which the former employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan, in which case the health care service plan shall notify the former employee or spouse or both of the right to a conversion plan in accordance with Section 1373.6.

(c) (1) If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA, the former spouse may further continue benefits beyond the date coverage under COBRA ends, as set forth in paragraph (2) of subdivision (b). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA had

remained in force. Continuation coverage following the end of COBRA is subject to payment of premiums to the health care service plan. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the employer or former employer.

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B) the date the individual is covered under any group health plan not maintained by the employer, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan, in which case the health care service plan shall notify the former spouse of the right to a conversion plan in accordance with Section 1373.6.

(d) (1) If the premium charged to the employer for a specific employee is adjusted for the age of the specific employee on other than a composite basis, the rate for continuation coverage under this section shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former employee electing continuation coverage. If the coverage continued is that of a former spouse, the premium charged shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former spouse selecting continuation coverage.

(2) If the premium charged to the employer for a specific employee is not adjusted for age of the specific

employee, then the rate for continuation coverage under this section shall not exceed 213 percent of the applicable current group rate. For purposes of this section, the ''applicable current group rate'' means the total premiums charged by the health care service plan for coverage for the group, divided by the relevant number of covered persons. However, in computing the premiums charged to the specific employer group, the health care service plan shall not include consideration of the specific medical care expenditures for beneficiaries receiving continuation coverage pursuant to this section.

(e) For purposes of this section, ''COBRA'' means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as amended.

(f) For the purposes of this section, ''former spouse'' means either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

SEC. 8. Section 10116.5 of the Insurance Code is amended to read:

10116.5. (a) Every policy of disability insurance that is issued, amended, delivered, or renewed in this state on or after January 1, 1996, that provides hospital, medical, or surgical expense coverage under an employer-sponsored group plan for an employer subject to COBRA, as defined herein, including a carrier providing replacement coverage under Section 10128.3, shall further offer the former employee the opportunity to continue benefits as required under subdivision (b), and shall further offer the former spouse of an employee or former employee the opportunity to continue benefits as required under subdivision (c).

(b) (1) In the event a former employee who worked for the employer for at least five years prior to the date of termination of employment and who is 60 years of age

or older on the date employment ends is entitled to and so elects to continue benefits under COBRA for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under COBRA ends, as set forth in paragraph (2). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA had remained in force. For the employee or spouse, continuation coverage following the end of COBRA is subject to payment of premiums to the insurer. Individuals ineligible for COBRA are not entitled to continuation coverage under this section. Premiums for continuation coverage under this section shall be billed by, and remitted to, the insurer in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the insurer's group contract with the former employer.

(2) The former employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the insurer in writing within 30 calendar days prior to the date continuation coverage under COBRA is scheduled to end.

(3) The continuation coverage shall end automatically on the earlier of (A) the date the individual reaches age 65, (B) the date the individual is covered under any group health plan not maintained by the employer, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) for a spouse, five years from the date on which continuation coverage under COBRA was scheduled to end for the spouse, or (E) the date on which the former employer terminates its group contract with the insurer and ceases to provide coverage for any active employees through that insurer,

in which case the insurer shall notify the former employee or spouse or both of the right to a conversion policy.

(c) (1) If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA, the former spouse may further continue benefits beyond the date coverage under COBRA ends, as set forth in paragraph (2) of subdivision (b). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA had remained in force. Continuation coverage following the end of COBRA is subject to payment of premiums to the insurer. Premiums for continuation coverage under this section shall be billed by, and remitted to, the insurer in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the insurer's group contract with the employer or former employer.

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B) the date the individual is covered under any group health plan not maintained by the employer, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group contract with the insurer and ceases to provide coverage for any active employees through that insurer, in which case the insurer shall notify the former spouse of the right to a conversion policy.

(d) (1) If the premium charged to the employer for a specific employee is adjusted for the age of the specific employee on other than a composite basis, the rate for continuation coverage under this section shall not exceed 102 percent of the premium charged by the insurer to the

employer for an employee of the same age as the former employee electing continuation coverage. If the coverage continued is that of a former spouse, the premium charged shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former spouse selecting continuation coverage.

(2) If the premium charged to the employer for a specific employee is not adjusted for age of the specific employee, then the rate for continuation coverage under this section shall not exceed 213 percent of the applicable current group rate. For purposes of this section, the ''applicable current group rate'' means the total premiums charged by the insurer for coverage for the group, divided by the relevant number of covered persons. However, in computing the premiums charged to the specific employer group, the insurer shall not include consideration of the specific medical care expenditures for beneficiaries receiving continuation coverage pursuant to this section.

(e) For purposes of this section, ''COBRA'' means Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as amended.

(f) For the purposes of this section, ''former spouse'' means either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

SEC. 9. Section 10194.7 of the Insurance Code is amended to read:

10194.7. (a) (1) Every Medicare supplement policy and certificate shall contain, on the first page, the applicable provision or provisions on renewability, continuation and conversion, appropriately captioned. This disclosure shall include any reservation by the insurer of the right to change premium and any

automatic renewal premium increases based on the insured's age.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specially 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 date of issue or at 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 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 insurance policies, or if the increased benefits or coverage is required by law. Where 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.

(3) If a Medicare supplement policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(4) Every Medicare supplement policy and certificate shall prominently disclose, in no less than 10-point upper case type, on the first page of the policy, certificate, and the outline of coverage, that the applicant has the right to return the policy or certificate, via regular mail, within 30 days after receiving it, if the insured is not satisfied for any reason, and that the full premium will be refunded.

(b) (1) (A) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, every insurer providing Medicare supplement insurance to a resident of California shall notify its insureds of modifications it has made to Medicare supplement forms in a format acceptable to the commissioner.

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 policy, and inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(B) 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.

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

(2) Insurers issuing disability policies, certificates, or contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for Medicare by reason of age, shall provide to all applicants a Medicare Supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioner and the Health Care Financing Administration. Delivery of the buyer's guide shall be made whether or not the policies, certificates, or contracts are advertised, solicited, or issued as Medicare supplement policies. Except in the case of direct response insurers, delivery of the buyer's guide shall be made to the applicant at the time of application and acknowledgement of receipt of the buyer's guide shall be obtained by the insurer. Direct response insurers shall deliver the buyer's guide to the applicant upon request, but not later than at the time the policy is delivered.

(3) Any disability insurance policy, including a disability income policy, a basic, catastrophic or major medical expense policy, or single premium nonrenewal policy or certificate issued to persons eligible for Medicare, that is not a Medicare supplement policy or a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), or other policy identified in subdivision (b) of Section 10192.05, 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. The notice shall either be printed or attached to

the first page of the outline of coverage. 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 CERTIFICATE]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(c) (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 acknowledgement 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 upper case 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) through (H), shall be capitalized, centered and printed in boldface type. The outline of coverage shall include the items, and in the same order, specified in the chart set forth in paragraph (4) of subdivision (C) of Section 16 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners on July 30, 1991.

(A) The cover page shall contain the 10-plan (A through J) chart. 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 10 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 test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Health Care Financing Administration 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.'' ''If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP and ask how to contact

your local Health Insurance and Counseling Program (HICAP) office. HICAP is a service provided free of charge by the State of California.''

(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, to 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) An example showing a physician's charge, which is equal to or less than the allowable limiting charge for the current year, of two thousand dollars ($2,000), the amount that Medicare would approve, the amount that Medicare would pay, the amount that the policy or certificate would pay, and any amount that would be owed by the insured, assuming that the annual deductible has already been paid. The statement shall be prominently displayed and in type no smaller than other type on the page.

(J) 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.

SEC. 9.5. Section 10194.7 of the Insurance Code is amended to read:

10194.7. (a) (1) Every Medicare supplement policy and certificate shall contain, on the first page, the applicable provision or provisions on renewability, continuation and conversion, appropriately captioned. This disclosure shall include any reservation by the insurer of the right to change premium and any automatic renewal premium increases based on the insured's age.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specially 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 date of issue or at 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 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 insurance policies, or if the increased benefits or coverage is required by law. Where 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.

(3) If a Medicare supplement policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and be labeled as ''Preexisting Condition Limitations.''

(4) Every Medicare supplement policy and certificate shall prominently disclose, in no less than 10-point upper case type, on the first page of the policy, certificate, and the outline of coverage, that the applicant has the right to return the policy or certificate, via regular mail, within 30 days after receiving it, if the insured is not satisfied for any reason, and that the full premium will be refunded.

(b) (1) (A) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, every insurer providing Medicare supplement insurance to a resident of California shall notify its insureds of modifications it has made to Medicare supplement forms in a format acceptable to the commissioner.

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 policy, and inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(B) 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.

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

(2) Insurers issuing disability policies, certificates, or contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for Medicare by reason of age, shall provide to all applicants a Medicare Supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioner and the Health Care Financing Administration. Delivery of the buyer's guide shall be made whether or not the policies, certificates, or contracts are advertised, solicited, or issued as Medicare supplement policies. Except in the case of direct response insurers, delivery of the buyer's guide shall be made to the applicant at the time of application and acknowledgement of receipt of the buyer's guide shall be obtained by the insurer. Direct response insurers shall deliver the buyer's guide to the applicant upon request, but not later than at the time the policy is delivered.

(3) Any disability insurance policy, including a disability income policy, a basic, catastrophic or major medical expense policy, or single premium nonrenewal policy or certificate issued to persons eligible for Medicare, that is not a Medicare supplement policy or a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), or other policy identified in subdivision (b) of Section 10192.05, 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. The notice shall either be printed or attached to the first page of the outline of coverage. 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 CERTIFICATE]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(c) (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 acknowledgement 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 upper case 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) through (H), shall be capitalized, centered and printed in boldface type. The outline of coverage shall include the items, and in the same order, specified in the chart set forth in paragraph (4) of subdivision (C) of Section 16 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners on July 30, 1991.

(A) The cover page shall contain the 10-plan (A through J) chart. 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 10 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 test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Health Care Financing Administration 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.''

The disclosure required by this paragraph, as revised by amendments made during the 1996 portion of the 1995–96 Regular Session, shall be included in the required disclosure form no later than January 1, 1998.

(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, to 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) An example showing a physician's charge, which is equal to or less than the allowable limiting charge for the current year, of two thousand dollars ($2,000), the amount that Medicare would approve, the amount that Medicare would pay, the amount that the policy or certificate would pay, and any amount that would be owed by the insured, assuming that the annual deductible has already been paid. The statement shall be prominently displayed and in type no smaller than other type on the page.

(J) 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.

SEC. 10. Section 10194.8 of the Insurance Code is amended to read:

10194.8. (a) No Medicare supplement insurer 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 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. 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 10195, except as provided for in paragraph (1) of subdivision (b).

(b) (1) In determining whether an exclusion of benefits for a preexisting condition may be applied to any person during the open enrollment period provided in this section, a Medicare supplement insurer shall credit the time the person was covered under qualifying prior coverage, provided the individual becomes eligible for coverage under the Medicare supplement policy:

(A) Within 180 days of the termination of any qualifying prior coverage if the qualifying prior coverage is offered through employment or sponsored by an employer and if the Medicare supplement insurance is offered through succeeding employment or sponsored by a succeeding employer, and is not in violation of the Medicare Secondary Payer provision of Section 1862(b) of the Social Security Act (42 U.S.C. Sec. 1395y(b)).

(B) In cases not covered by paragraph (1), within 30 days of the termination of any other qualifying prior coverage.

(2) For purposes of this section, qualifying prior coverage means any of the following:

(A) Any individual or group policy, contract, or program that is written or administered by a disability insurer, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, long-term care insurance, dental coverage, vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law,

automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(B) The medicaid program pursuant to Title XIX of the Social Security Act.

(C) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care, not including the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) An individual enrolled in Medicare Part B by reason of disability will be entitled to open enrollment described in this section for six months after he or she reaches age 65. Every insurer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that insurer at the time of application. Insurers shall not discourage sales during the open enrollment period by any means, including the altering of the commission structure.

(d) An individual who is 65 years of age or older and enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(1) 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. For purposes of this section, ''employer-sponsored retiree health plan'' includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(2) 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.

(e) An individual who is 65 years of age or older and 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.

(f) 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, with the exception of a Medicare Select policy, that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no Medicare supplement insurer 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. A Medicare supplement insurer shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

SEC. 11. Section 10195.1 of the Insurance Code, as added by Section 21 of Chapter 287 of the Statutes of 1992, is amended to read:

10195.1. (a) A Medicare supplement policy or certificate form shall not be issued or renewed unless the form can be expected to return to the insured aggregate benefits, not including anticipated refunds or credits, of at least 75 percent of the aggregate amount of premiums earned in the case of group policies, or at least 65 percent of the aggregate amount of premiums earned in the case of individual policies. These loss ratios shall also apply to prestandardized policies and certificates issued prior to July 21, 1992.

(1) Loss ratio experience shall be calculated as incurred claims for each calendar year, by year of issue, excluding administrative expenses or policy reserves, divided by premiums earned from all payment modes, including policy fees.

(2) The minimum loss ratio in this subdivision shall apply to all forms that have been in force three years or more. In the case of forms that have been in force less than three years, the commissioner shall determine whether the expected third-year loss ratio will meet the appropriate minimum standard.

(b) (1) Every insurer of Medicare supplement insurance shall file annually, for each form in force in California, its rates, rating schedule, and supporting documentation. The filings shall include an actuarial memorandum describing the historical experience and expected costs relative to any premium changes, premium income, rates or rating schedules, claims reports, including claims lag reports, and other documentation as prescribed or requested by the commissioner. The filings shall demonstrate that unpaid claims reserves and renewal rate filings are based on acceptable actuarial principles that will result in the required minimum loss ratio standards over the renewal period.

(2) The combined filings shall include appropriate riders, endorsements, and outlines of coverage, and shall be submitted prior to the effective date of changes, or announcement that no changes will occur, in Medicare benefits, and shall clearly describe the revised policy benefits.

(3) An insurer shall not use or change premium rates unless the rates, rating schedule, and supporting documentation have been approved by the commissioner in writing.

(4) If a rate filing or other information received by the commissioner indicates that a loss ratio fails to meet the minimum standard established in this section, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the appropriate loss ratio. The commissioner may require the insurer to file and implement a corrective plan, which may include premium adjustments, dividends, benefit increases, refunds, premium credits, or any combination of methods reasonably calculated to achieve the

minimum loss ratio. The corrective plan shall be approved by the commissioner before implementation.

(5) If the commissioner determines that a failure to meet the minimum loss ratio requirements is due to unusual experience fluctuations, economic conditions, or other nonrecurring conditions, the commissioner may exempt the form from the need for a corrective plan for that year. Any exemption shall be in writing and specify the reasons for granting the exemption.

(6) If an insurer fails to file or implement the corrective plan in paragraph (4) in a timely manner, the commissioner shall withdraw approval of the form as provided in Section 10293. This remedy shall be in addition to any other remedy available under law. Any plan, report, exemption, or other document prepared pursuant to this subdivision shall be accessible as a public record.

(7) For policies issued prior to July 21, 1992, expected claims in relation to premiums shall meet:

(A) The originally filed anticipated loss ratio when combined with the actual experience since inception.

(B) The appropriate loss ratio requirement from subdivision (a), when combined with actual experience beginning with the effective date of this act.

(C) The appropriate loss ratio requirement from subdivision (a), over the entire future period for which those rates are computed to provide coverage.

(D) In meeting the requirements in subparagraphs (A), (B), and (C) for filings for policies issued prior to July 21, 1992, and for purposes of attaining credibility, an insurer may combine experience under policy forms if the policy forms have a common loss ratio requirement and provide substantially similar coverage. The commissioner may disapprove the combining of experience if combining the forms appear not to be in the best interest of the policyholder. Once a combined form is adopted, the insurer may not separate the experience except with the approval of the commissioner.

(c) (1) An insurer shall collect and file for approval by the commissioner, by May 31 of each year, the data

contained in the reporting form set forth in Appendix A of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners on July 30, 1991.

(2) If on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since exception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in the standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) A refund or credit shall be made when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level.

(4) A refund or credit shall be made on or before September 30 in the year following the year upon which the refund or credit is based. The refund or credit shall include interest from the end of the calendar year to the date of the refund at a rate no less than the average for 13-week Treasury notes.

(d) The commissioner shall adopt regulations by July 30, 1993, that shall set forth specific data and documentation required for submission in annual rate filings pursuant to subdivisions (a), (b), and (c), and specify those minimum standards necessary for approval of those rate filings.

(e) The commissioner may conduct a public hearing to gather information concerning a request for a rate increase on any form in force in California if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance may be made without consideration of any corrective plan implemented for the reporting period. Public notice of the hearing shall be furnished as deemed appropriate by the commissioner.

(f) Mass-marketed policies, as defined in paragraph (1) of subdivision (c) of Section 10293, issued prior to the effective date of this section shall be subject to the individual loss ratio specified in subdivision (a).

SEC. 12. Section 10197 of the Insurance Code is amended to read:

10197. (a) No insurer, broker, agent, or other person shall cause an insured to replace a Medicare supplement insurance policy unnecessarily. In recommending replacement of any Medicare supplement insurance, an agent shall make reasonable efforts to determine the appropriateness to the potential insured.

(b) Application forms shall include the following statements and questions designed to elicit information as to whether, as of the date of the application, the applicant has other Medicare supplement insurance in force, or whether the Medicare supplement policy or certificate is intended to replace any other disability coverage presently in force. A supplementary application or other form to be signed by the applicant and agent containing those questions may be used unless the coverage is sold without an agent.

(1) Statements:

(A) You do not need more than one Medicare supplement policy.

(B) You may be eligible for benefits under Medi-Cal or medicaid and may not need a Medicare supplement policy.

(C) Benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to Medi-Cal or medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or medicaid. Once you are no longer eligible for Medi-Cal or medicaid, your insurance policy will be reinstituted if you request it within 90 days after losing entitlement.

(D) “If you want to discuss buying Medicare supplement insurance with a trained insurance

counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.''

(2) Questions:

(A) Do you have any other Medicare supplement insurance coverage, including an HMO contract? If so, with what company?

(B) Do you have any other health or disability insurance coverage? If so, what company? What kind of policy? Would the benefits duplicate the benefits in this Medicare supplement policy?

(C) Do you intend to replace any health or disability insurance coverage with this policy?

(D) Are you eligible for or receiving benefits from Medi-Cal?

(c) Each agent shall list, on the same form, any other disability insurance policies he or she or his or her agency has sold to the applicant. The list shall include all policies that are still in force and all policies sold in the last five years that may no longer be in force.

(d) In the case of the direct response insurer, a copy of the application, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant upon or before delivery of the policy.

(e) Upon determining that a sale will involve replacement, an insurer or its agent, shall furnish the applicant, prior to issuing or delivering the Medicare supplement policy or certificate, a replacement notice. Direct response insurers shall deliver the replacement notice along with the policy or certificate. One copy of the notice signed by the applicant and the agent or insurer shall be provided to the applicant and an additional signed copy shall be retained by the insurer as provided in Section 10508. The replacement notice shall be printed

in no less than 10-point type in substantially the following form:

[Insurer's name and address]

NOTICE TO APPLICANT PLANNING TO REPLACE MEDICARE SUPPLEMENT COVERAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE FUTURE.

If you intend to cancel or terminate existing Medicare supplement insurance and replace it with coverage issued by [company name], please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT: I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

__ Additional benefits that are: _____

__ No change in benefits, but lower premiums.
__ Fewer benefits and lower premiums.
__ Other reasons specified here: _____

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

(Signature of Agent, Broker, or Other Representative)

_____

(Signature of Applicant)

_____

(Date)

SEC. 13. Section 10197.1 of the Insurance Code is amended to read:

10197.1. (a) Every insurer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall do all of the following:

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

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

(3) Display prominently on the first page of the policy the following:

''Notice to buyer: This policy may not cover all of your medical costs.''

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

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

(b) In addition to other unfair trade practices identified in this code, the following acts and practices are prohibited:

(1) Twisting: Knowingly making any misleading representation or incomplete or fraudulent comparison

of any insurance policies of insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High Pressure Tactics: Employing any method of marketing having the affect 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: Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(c) The terms ''Medicare Supplement'' or ''Medicare Wrap-Around'' or words of similar import shall not be used unless the coverage and the forms have been approved by the commissioner as in compliance with this article. The term ''Medigap'' shall not be used.

SEC. 14. Section 10197.6 of the Insurance Code is amended to read:

10197.6. (a) An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. Every insurer shall file with the commissioner its commission structure or an explanation of the insurer's plan to comply with this provision.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period, and shall be provided for at least five years.

(c) For purposes of this section, ''commission'' or ''compensation'' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal

of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards, and finders fees.

(d) If coverage is replaced, no agent, subagent, or other producer shall receive commission or compensation, and no insurer or other entity shall pay commission or compensation, in a greater amount than the renewal compensation for the original coverage.

SEC. 15. Section 2800.2 of the Labor Code is amended to read:

2800.2. (a) Any employer, employee association, or other entity otherwise providing hospital, surgical, or major medical benefits to its employees or members is solely responsible for notification of its employees or members of the conversion coverage made available pursuant to Part 6.1 (commencing with Section 12670) of Division 2 of the Insurance Code or Section 1373.6 of the Health and Safety Code.

(b) Any employer, employee association, or other entity, whether private or public, that provides hospital, medical, or surgical expense coverage that a former employee may continue under Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, or Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as may be later amended (hereafter ''COBRA''), shall, in conjunction with the notification required by COBRA that COBRA continuation coverage will cease and conversion coverage is available, and as a part of the notification required by subdivision (a), also notify the former employee, spouse, or former spouse of the availability of the continuation coverage under Section 1373.621 of the Health and Safety Code, and Sections 10116.5 and 11512.03 of the Insurance Code.

SEC. 16. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 17. Section 9.5 of this bill incorporates amendments to Section 10194.7 of the Insurance Code proposed by both this bill and SB 1581. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 1997, but this bill becomes operative first, (2) each bill amends Section 10194.7 of the Insurance Code, and (3) this bill is enacted after SB 1581, in which case Section 10194.7 of the Insurance Code as amended by Section 9 of this bill shall remain operative only until the operative date of SB 1581, at which time Section 9.5 of this bill shall become operative.

SEC. 18. 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 Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure the continued availability of Medicare supplement health insurance, it is necessary that this act take effect immediately.

SEC. 19. Sections 6, 7, 8, 10, and 15 shall become operative January 1, 1997.

Approved _____, 1996

_____

Governor