

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
BULLETIN 2001-1, JANUARY 22, 2001 (CORRECTED¹)**

TO: ALL ISSUERS OF MEDICARE SUPPLEMENT INSURANCE

**RE: NEW OPEN ENROLLMENT REQUIREMENTS FOR MEDICARE SUPPLEMENT INSURANCE:
SENATE BILL 1814, (SENATOR SPEIER) CHAPTER 707, STATUTES 2000**

The purpose of this Bulletin is to notify insurers that issue Medicare Supplement Insurance in California about changes in the law affecting open enrollment for Medicare Supplement Insurance for persons receiving Medicare benefits by reason of age or disability and for persons who lose coverage under employee welfare benefit plans, HMOs with Medicare contracts, or Medicare+Choice plans. Senate Bill 1814, (Senator Speier) Chapter 707, statutes 2000, enacted September 27, 2000, made some changes effective upon enactment and some effective January 1, 2001.

Section 10192.11 and 10192.12 of the Insurance Code, as added by Senate Bill 764 of the 1999-2000 regular session of the California Legislative and as amended by Senate Bill 1814 provide in part and in summary as follows:

1. Pursuant to section 10192.11(a), issuers shall not deny or condition the issuance of effectiveness of any Medicare Supplement policy or certificate available for sale in California, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant. This applies in the case of an application for a policy or certificate 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. Prior to amendment, this "open enrollment period" extended six months from the time an individual attained age 65.

Each Medicare Supplement policy and certificate currently available from an issuer must be made available to all applicants who qualify under section 10192.11(a) and who are 65 years of age or older.

2. Pursuant to section 10192.11(a), issuers must make available Medicare Supplement plans A, B, C, F *and* (as determined by the issuer) at least one plan among plans H, I, and J, which includes coverage for prescription medications, to any applicant who qualifies under section 10192.11(a) who is 64 years of age or younger, who is enrolled in Medicare Part B, and who does not have end-stage renal disease. This applies if such plans are currently available from an issuer.

This new requirement, extending eligibility to persons under 65 who, under Federal law, are eligible for Medicare benefits by reason of disability (except for persons with end-stage renal disease), does not prevent issuers from determining premium rates for such persons as a separate risk classification. Nor does this amendment prevent exclusion of benefits for pre-existing conditions, *as defined, specified, and restricted by California law*. Nevertheless, issuers must give appropriate credit for prior coverage, as required, for example, by section 10192.11(b).

3. Pursuant to section 10192.11(d), an individual enrolled in Medicare Part B by reason of disability is entitled to open enrollment for six months after he or she first becomes eligible for Medicare Part B. During that time period, issuers must make available to every applicant qualified for open enrollment all policies and certificates offered by the issuer at the time of the individual's application. Furthermore, a one-time open enrollment period of 120 days, commencing January 1, 2001, applies for all individuals eligible for Medicare by reason of disability who do not have end-stage renal disease. This requirement became law on September 27, 2000.

4. Pursuant to section 10192.12, individuals who for specified reasons lose all or substantially all of their supplemental health benefits under an employee welfare benefit plan (and whose employer no longer provides insurance for such individuals that covers all of the payment for Medicare Part B coinsurance), under a Medicare+Choice plan, and HMO risk plan authorized by section 1876 of the Social Security Act, or a similar organization under a Federal demonstration project effective for periods before April 1, 1999, a health care prepayment plan under section 1833(a)(1)(A) of the Social Security Act, or under a Medicare SELECT policy, or because a Medicare Supplement insurer became insolvent, terminated an individual's policy, substantially violated a material provision of the policy, or materially misrepresented the policy's provisions, shall be entitled to purchase Medicare Supplement plans A, B, C, F, and (at the issuer's discretion) at least one of the plans among H, I, or J which provides coverage for prescription medications. This applies if such plans are currently available from an issuer.

The Department advises all issuers of Medicare Supplement Insurance in California to become familiar with the changes in California statutes made by Senate Bills 764 and 1814 and to promptly amend policy forms and practices to comply with the law as amended. Furthermore, if in any instance an issuer did not comply with any provision of the amended law on or after the effective date of any change in the law, and if that non-compliance caused harm or detriment to any individual, the issuer must take prompt action to correct the noncompliance and make whole the adversely affected individual.

Harry W. Low
Insurance Commissioner

ⁱ This document corrects three typographical errors that appeared in the original Bulletin 2001-1. Specifically, in the "RE" line and in the fourth line of the first full paragraph, the word "statues" has been corrected to read "statutes". Finally, the phrase "end-state renal disease," in the second line of the un-numbered paragraph between paragraphs numbered "2" and "3", has been corrected to read "end-stage renal disease."