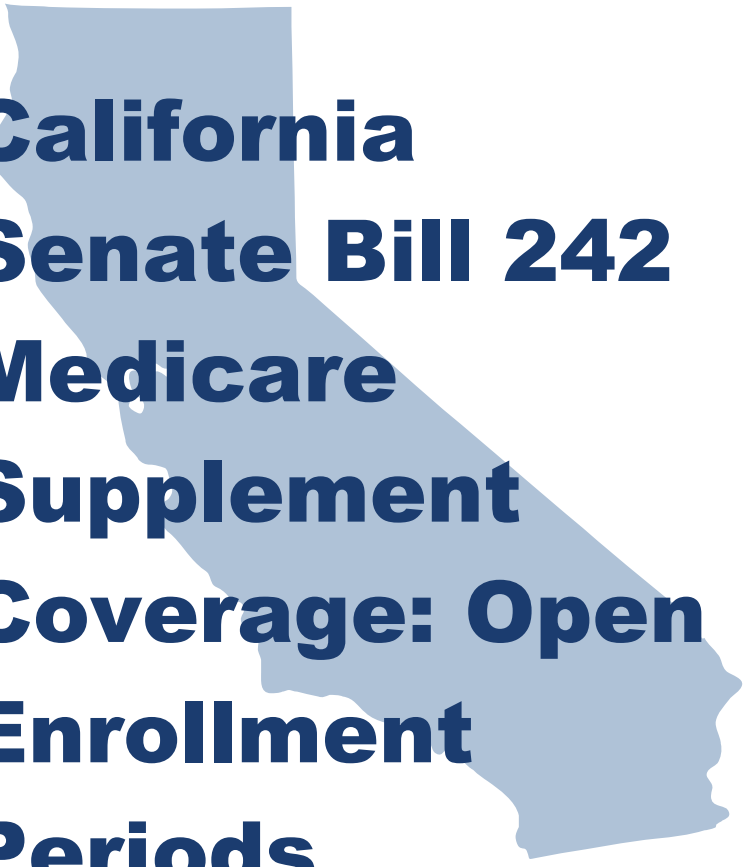
Abbreviated Analysis

California Senate Bill 242 Medicare Supplement Coverage: Open Enrollment Periods



Report to the 2025–2026
California State Legislature

APRIL 20, 2025

California Health Benefits
Review Program (CHBRP),
University of California, Berkeley

chbrp.org

KEY FINDINGS

Abbreviated Analysis of California Senate Bill 242

Medicare Supplement Coverage - Open Enrollment Periods

Summary to the 2025–2026 California State Legislature, April 20, 2025

CHBRP

Summary

California Senate Bill (SB) 242, as analyzed by California Health Benefits Review Program (CHBRP), would require an annual 90-day open enrollment period beginning each January 1st in which Medicare Supplement plans would be required to provide "guaranteed issue enrollment." Guaranteed issue policies ensure health insurance coverage to all applicants, regardless of their health status, claims experience, medical conditions, or age. This means insurers cannot deny coverage or charge higher premiums based on these factors. The bill also would allow beneficiaries with end-stage renal disease under the age of 65 years to enroll as well. Currently, the period of open enrollment for Medicare Supplemental Insurance occurs during the 6-month period beginning with the first day of the month in which a beneficiary first enrolls for benefits under Medicare Part B.

In 2026, approximately 6.6 million Californians will be enrolled in Medicare. This includes:

- 5 million with Medicare-only coverage, with sizable numbers of those enrolled in Medicare Supplement plans (Medigap) or Medicare Advantage plans.
- 1.6 million beneficiaries dually enrolled in Medicare and Medi-Cal with Medi-Cal providing coverage for Medicare deductibles and coinsurance (and Medi-Cal–only services).

Impact

- CHBRP estimates the average monthly premiums for Medicare Supplement policies will increase by $40.00 (14%) per member per month (PMPM). This is due to new enrollees in Medicare Supplements using disproportionately more services than the average enrollee at baseline. This is referred to as adverse selection.
- SB 242 is unlikely to impact Medi-Cal.

Context

Existing federal law provides for the Medicare Program, which is a public health insurance program for people 65 years of age and older, and eligible individuals with disabilities who are under 65 years of age. Existing federal law also provides for the issuance of Medicare Supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to the Medicare Program for hospital, medical, or surgical expenses. These expenses include coverage of Medicare deductible, copayment, or coinsurance amounts.

Existing California law places requirements on Medicare Supplement plans and policies that are regulated by the California Department of Insurance (CDI) or the California Department of Managed Health Care (DMHC). Existing law already allows for open enrollment during the 6-month period beginning with the first day of the month in which a beneficiary first enrolled for benefits under Medicare Part B.

Connecticut, Massachusetts, Maine, New York, Rhode Island, and Vermont require either continuous or annual guaranteed issue protections for Medicare Supplement for all beneficiaries in traditional Medicare ages 65 years and older, regardless of medical history.

Beneficiaries who currently have a Medicare Advantage plan or Traditional Medicare do not have federal guaranteed issue protection to switch into Medicare Supplement policies. They also do not have guaranteed issue protection if they voluntarily drop Medicare Supplement and wish to purchase a policy again later. However, there are some limited exceptions noted in the *Policy Context* section.

Bill Summary

SB 242 would require an annual 90-day period beginning each January 1st requiring "guaranteed issue" into Medicare Supplement plans. This new guaranteed enrollment period does not conflict or replace the existing 6-month open enrollment period that every Medicare beneficiary experiences when they sign up for

Part B. This bill would also remove the exclusion of otherwise qualified applicants who have end-stage renal disease (under the age of 65 years), thereby making Medicare Supplement benefit plans available to those individuals.

Impacts

Enrollment and Expenditures

The number of enrollees in Medicare Supplement policies will decrease by 6,400 (−1%) postmandate (see Table 3). Overall, the average monthly premiums for Medicare Supplement policies will increase by $40.00 (14%) per member per month (PMPM) due to SB 242, because new enrollees in Medicare Supplements will use more services than the average enrollee at baseline. 90,700 enrollees at baseline would disenroll from their coverage postmandate due to increases in premiums, whereas there are 84,300 new enrollees who will enroll in Medicare Supplements postmandate. The new entrants to the Medicare Supplement market are likely to be higher cost enrollees, and they will displace lower cost enrollees who find it advantageous to disenroll from their Medicare Supplement rather than pay higher premiums to continue their coverage. Note: these estimates are lower than those in the 2024 CHBRP analysis of bill AB 1236 (in 2024) because based on additional studies from other states, we have reduced the estimated disenrollment to 8% from last year's estimate (of SB 1236) of 14%, lowered the assumed shift of high cost cohorts to 7.5% from 20%, and also included the assumption of members leaving Medicare Advantage for Medicare Supplement policies due to network frustrations.

Adverse selection

Adverse selection occurs when lower cost or healthier patients opt out of more expensive plans or forego buying insurance until they need it, while higher cost or sicker patients actively buy more protective insurance (with additional out-of-pocket protections and/or benefits) to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase in that insurance product.

The expected increase in Medicare Supplement premiums from assuring Medicare Advantage enrollees who switch to Traditional Medicare can access affordable Medicare Supplement coverage would depend on the degree of adverse selection. It would also depend on the number of beneficiaries who, when switching to Traditional Medicare, enroll in Medicare Supplement compared to the number of overall Medicare Supplement enrollees. The degree of adverse selection for those switching to Traditional Medicare would likely increase if beneficiaries leaving Medicare Advantage had assured access to affordable Medicare Supplement coverage.

Medi-Cal

SB 242 is unlikely to impact Medi-Cal beneficiaries. Medicare Supplement plans are not generally needed (nor eligible) for individuals who are also eligible for Medicaid. Medicare Supplement plans are private insurance policies that help pay for out-of-pocket costs like copayments, coinsurance, and deductibles that Traditional Medicare doesn't cover. If a person is eligible for Medicaid, their Medicaid coverage often covers these same costs, making a Medicare Supplement plan redundant or unnecessary. However, beneficiaries may suspend Medicare Supplement for up to 2 years if they become eligible for Medicaid, in which case, they have no new medical underwriting or waiting periods for pre-existing conditions when they restart their Medicare Supplement.

Long-Term Impacts

CHBRP's estimated premium increase is highly dependent upon the chosen assumptions. However, based on current market conditions and the assumption that 7.5% of higher cost or higher need applicants would enroll in a plan, it is likely that an equilibrium will be established in the Medicare Supplement market around the estimated premium increase of 14%, as stated in this report.

Table of Contents

Lists of Tables and Figures

Acronyms and Abbreviations

AB – Assembly Bill
ACA – Affordable Care Act
CA – California
CDI – California Department of Insurance
CHBRP – California Health Benefits Review Program
CMS – Centers for Medicare and Medicaid Services
DMHC – Department of Managed Health Care
ESRD – end-stage renal disease
HMO – health maintenance organization
SB – Senate Bill

Introduction

The California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP) provide an abbreviated analysis of the financial impacts of California Senate Bill 242, Medicare Supplements. In 2024, California introduced Assembly Bill 1236, with similar provisions as SB 242. This analysis is built from that earlier CHBRP analysis, with refinements based on new literature and supporting data.

SB 242 would require a new open enrollment period for Medicare Supplement Insurance that lasts 90 days each year (January 1st to March 31st) where any Medicare beneficiary could enroll in guaranteed issue supplement coverage. This new period does not conflict or replace the existing 6-month open enrollment period that every Medicare beneficiary experiences when they sign up for Part B. Under SB 242, plans would be prohibited from discriminating in the pricing of monthly premiums or denying applicants for pre-existing conditions due to age, applicant health status, claims experience, receipt of health care, or medical condition.

Medicare is a federal health insurance program for people aged 65 years and older, people under 65 years with certain disabilities, and people of all ages with end-stage renal disease (ESRD). Nationally, approximately 67.3 million people are enrolled in Medicare (as of April of 2024). In 2022, 12.5 million Medicare beneficiaries, or 42% of all Traditional Medicare beneficiaries, had a Medicare Supplemental Insurance policy.

Approximately 6.6 million Californians are enrolled in Medicare, including 5 million Medicare beneficiaries, and 1.6 million beneficiaries dually eligible for Medicare and Medi-Cal. Across all Medicare beneficiaries in the state, approximately 90 percent are age 65 years and older, and 10% are under age 65 years.

A "Medicare Supplement plan" (also called Medigap, but in this analysis referred to as Medicare Supplement plan) is an additional insurance policy purchased from a private insurer to help cover out-of-pocket costs that “Traditional Medicare” doesn't pay, such deductibles and copayments. "Medicare Advantage" is a type of health plan offered by private insurers that acts as an alternative to Traditional Medicare, often including additional benefits such as vision and dental care, and limits on cost sharing and out-of-pocket spending. Eligible beneficiaries cannot have both a Medicare Supplement and a Medicare Advantage plan. This analysis projects the potential impacts of SB 242 on estimated baseline premiums and enrollment in Medicare Supplement policies and plans regulated by the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC).

The predicted increases in Medicare Supplement plan premiums due to SB 242 are largely driven by what is commonly known as adverse selection. Adverse selection occurs when lower cost or healthier patients opt out of more expensive plans or forego buying insurance until they need it, while higher cost or sicker patients actively buy more generous protective insurance to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase in that insurance product.

For a more extensive primer on the structure of Medicare, please see the *Background* section.

Back to Table of Contents

Policy Context

Medicare is a federal health insurance program for people aged 65 years and older, people under 65 years with certain disabilities, and people of all ages with end-stage renal disease (ESRD).[1] Medicare includes several parts,[2] described in more detail in the *Background on Medicare* section. This legislation (SB 242) focuses on Medicare Supplement plans,[3] a form of private health insurance. These plans are designed to help beneficiaries with uncovered and high out-of-pocket expenses by pooling risk and spreading enrollee costs over the course of the year (through monthly premium payments), Medicare Supplement plans can make health care costs more predictable and manageable for beneficiaries.

Medicare Part C, also known as Medicare Advantage (MA), is also a form of private health insurance. Medicare Advantage plans often have caps on out-of-pocket spending, which provide additional financial protection when compared to Traditional Medicare. Medicare Advantage is popular in California, with 51% of Medicare beneficiaries enrolled in a Medicare Advantage plan (Healthinsurance.org, 2023). In California, 3.5 million people are enrolled in a Medicare Advantage plan (Healthinsurance.org, 2023). If enrollees join a Medicare Advantage plan during their Initial Enrollment Period, they can change to another Medicare Advantage plan (with or without drug coverage) or go back to Traditional Medicare (with or without a drug plan) within the first 3 months they have Medicare Part A & Part B. In addition, in California, Medicare Advantage members can switch back to Traditional Medicare (Parts A and B) during specific enrollment periods, such as the Annual Enrollment Period (October 15 to December 7) and the Medicare Advantage Open Enrollment Period (January 1 to March 31).

Rules for Medicare Supplement Premiums

Depending on state regulations, Medicare Supplement insurers[4] may set premiums based on community rating, issue-age rating, or attained-age rating. Under each of the three, quite different premium-setting methodologies, insurers may annually request premium increases from state insurance commissioners for inflation and other changes (such as updated estimates of actuarial factors).

Community rating charges enrollees generally the same premium, regardless of age or gender, which results in younger beneficiaries paying more than their actuarially expected cost and older beneficiaries paying less.

Issue-age rating sets premiums based on the age of a beneficiary when first enrolling in a Medicare Supplement plan, and premiums don't increase as the individual ages. As a result, a beneficiary who joined a Medicare Supplement plan at age 65 years will have lower premiums than a beneficiary of the same age who initially enrolled at age 72 years.

Attained-age rating sets premiums based on the current age of a beneficiary, allowing premiums to increase as a person ages. Under attained-age rating, beneficiaries at 65 years incur relatively low premiums that escalate annually, so that a beneficiary at age 75 years pays more than one who is 65 years of age would in that year; two beneficiaries of the same age pay the same premium, regardless of when each initially enrolled.

Guaranteed Issue and Rules for New and Existing Beneficiaries

Under current federal law, insurance companies that sell Medicare Supplement plans and policies may refuse to sell a policy to an applicant with certain medical conditions, or who has had certain medical procedures or used specific prescription drugs, outside of open enrollment or a guaranteed issue period. This contrasts with other insurance products

[1] Beneficiaries with end-stage renal disease (permanent kidney failure, sometimes abbreviated ESRD, require dialysis or a transplant.
[2] Part A (Hospital Insurance), and Part B (Medical Services): Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Part B covers outpatient care, some doctors' services, medical supplies, and preventive services. Medicare Part D (prescription drug coverage) helps cover the cost of prescription drugs (including many recommended shots or vaccines). Medicare's benefit design includes substantial cost-sharing requirements in the form of deductibles, copays, and coinsurance, with no limit on out-of-pocket spending in Traditional Medicare (Parts A and B).
[3] Medigap plans, also known as Medicare Supplement Insurance, were introduced in 1966, the same year Medicare, signed into law on July 30, 1965, began.
[4] For additional information on choosing Medigap plans, please see: https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf.

(post ACA), such as plans sold in the ACA Marketplace or Medicare Advantage, which are not permitted to deny coverage based on pre-existing conditions at any time.

Guaranteed issue means that an insurer cannot deny an applicant's (Medicare Supplement plan) coverage, impose waiting periods, exclude pre-existing medical conditions, or charge higher premiums because of past or present health issues. After applicants enroll in a Medicare Supplement plan or policy, federal rules generally prevent insurers from terminating coverage if premiums are paid.

Within 6 months of retirees enrolling in Medicare Part B, federal rules require guaranteed issue for Medicare Supplement, meaning insurers must accept applicants and not engage in medical underwriting. This precludes charging higher (health-related) premiums, imposing a waiting period, or not covering a preexisting condition. (Rules for people with disabilities vary by state.) State rules in Connecticut, Massachusetts, and New York require both community rating and guaranteed issue for Medicare Supplement, extending the federal protections for new retirees to all applicants. As a result, beneficiaries in these three states can shift from Medicare Advantage to Traditional Medicare and enroll in Medicare Supplement for the same premium as those remaining in Traditional Medicare.

Federal rules convey "trial rights" to re-enter the Medicare Supplement market on a guaranteed-issue basis for retirees who either enrolled in Medicare Advantage when initially eligible for Medicare or dropped their Medicare Supplement plan to join Medicare Advantage for the first time but want to switch to Traditional Medicare within their first year in Medicare Advantage (CMS, 2024). Medicare also requires guaranteed issue for other special circumstances, such as when a Medicare Supplement insurer goes bankrupt, an MA plan withdraws from a market (or a beneficiary moves out of the plan's service area), employer coverage ends, or a Medicare Supplement plan or Medicare Advantage plan misleads a beneficiary or otherwise doesn't follow applicable rules

Medicare Supplement plans are subject to both federal and state requirements. There are several key components of premium setting that are impacted by regulatory requirements. Existing California law places requirements on Medicare Supplement plans and policies that are regulated by the California Department of Insurance (CDI) or the California Department of Managed Health Care (DMHC). Existing law already allows for open enrollment during the 6-month period beginning with the first day of the month in which a beneficiary first enrolled for benefits under Medicare Part B.

SB 242 would entitle an individual enrolled in Medicare Part B to a 90-day *annual* open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare Supplement coverage available from an issuer, as specified, creating a "guaranteed issue period." This places requirements on plans and policies prohibiting issuers of Medicare Supplement coverage in California from denying or conditioning the issuance or effectiveness of any Medicare Supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. This bill would also delete the exclusion of otherwise qualified applicants who have end-stage renal disease, thereby making the specified Medicare Supplement benefit plans available to those individuals.

Points of alignment and variation between the existing state law and SB 242 are noted below in Table 1.

Table 1. Alignment and Variation Between Existing State Law* and SB 242

Issue	Existing State Law* Requires	SB 242 Would Require
Initial open enrollment –	During the 6-month period beginning with the first day of the first month in which a person is both 65 years of age or older and is enrolled for benefits under Medicare Part B.	SB 242 would require no change to the initial enrollment. During the 6-month period beginning with the first day of the first month in which a person is both 65 years of age or older and is enrolled for benefits under Medicare Part B.
Open enrollment –	Six months following any of the following: (1) termination of employer sponsored plan/policy or loss of eligibility due to divorce or death of spouse; (2) termination of health care services for a military retiree or eligible spouse/dependent as a result of military base closure or beneficiary relocation. Sixty days following: (1) beneficiary relocation to a location not served by the plan/policy; (2) issuer termination of the plan/policy; (3) beneficiary loss of Medi-Cal eligibility. Annual 60-day open enrollment period commencing with the beneficiary's birthday – for a plan/policy of equal or lesser value (i.e., a beneficiary could choose another Medicare Supplement plan). Underwriting is allowed. Premium is based on attained age.	Annual 90-day open enrollment period beginning each January 1. During the new annual open enrollment period, underwriting is allowed and the monthly premium is based on the attained age of the beneficiary. Would prohibit denial/condition of issuance/effectiveness based on applicant health status, claims experience, receipt of health care, or medical condition.
ESRD	Does not require Medicare Supplement plans under the age of 65 years to enroll.	Prohibits denial/condition of issuance/effectiveness based on applicant age (allowing beneficiaries with ESRD under age 65 years to enroll).

Source: California Health Benefits Review Program, 2025.
Note: * HSC 1358.11 and INS 10192.91.

The eligibility requirements for Medicare are consistent across types of coverage. However, there are differences in enrollment periods and guaranteed issue/underwriting requirements. As of 2025, there are approximately 20 separate carriers offering Medicare Supplement policies in California. For individuals over the age of 65 years, California allows carriers to set premiums using any of the three methodologies (issue age, attained age and community rating), and most plans appear to use the community rated pricing approach to ensure fairness/equity across different age groups. (HMA, 2025). California does not require Medicare Supplement plans to offer coverage for Medicare beneficiaries under the age of 65 years who have end-stage renal disease (HMA, 2025). However, California does offer an open enrollment period for those under 65 years eligible for Medicare due to disability (excluding ESRD).

Beneficiaries who currently have a Medicare Supplement plan or policy do not have federal guaranteed issue protections to switch Medicare Supplement plans. They also do not have guaranteed issue protections if they voluntarily drop their Medicare Supplement plan and wish to purchase a plan or policy again later. However, beneficiaries may suspend their Medicare Supplemental plan for up to 2 years if they become eligible for Medicaid, in which case they have no new medical underwriting or waiting periods for pre-existing conditions when they restart their Medicare Supplement coverage (Freed et al., 2024b).

However, Medicare Advantage enrollees currently do have guaranteed issue rights to purchase a Medicare Supplement plan to augment coverage under Traditional Medicare in the following circumstances:

- Their Medicare Advantage plan discontinues coverage in their area;
- They move to a new area and can no longer access coverage from their Medicare Advantage plan;
- Their Medicare Advantage plan is terminated; or
- Their Medicare Advantage plan commits fraud.

Requirements in Other States

New Hampshire House Bill 774, introduced in January of 2025, would require Medicare supplemental policies to cover pre-existing conditions and use community rating. Ohio has a similar bill that limits pre-existing condition limits in House Bill 24, introduced in its current legislative session,[5] as does Rhode Island, with two introduced bills: Senate Bill 267[6] and House Bill 5499.[7]

Connecticut, Massachusetts, Maine, New York (Boccuti et al., 2018), Rhode Island (Rhode Island Office of the Health Insurance Commissioner, 2023), and Vermont (Ball, 2023) require either continuous or annual guaranteed issue protections for Medicare Supplement plans for all beneficiaries in Traditional Medicare ages 65 years and older, regardless of medical history. Minnesota has passed a similar law that will be in effect in 2025 (Minesota Legislature, 2023). Guaranteed issue protections prohibit insurers from denying a Medicare Supplement to eligible applicants, including people with pre-existing conditions, such as diabetes and heart disease.

Other State Activity

In the last legislative session, Hawai'i considered a similar bill that did not pass (Hawai'i Legislature, 2023).[8]

Several states have also introduced legislation to expand consumer protections in Medicare Supplement plans. For example, California lawmakers introduced similar legislation in 2024. The 2024 legislation, AB 1236,[9] would have required guaranteed issue rights during a 90-day annual open enrollment period but did not include ESRD enrollees. Iowa lawmakers introduced legislation[10] to require guaranteed issue rights during a 30-day annual open enrollment period. Vermont lawmakers also introduced legislation[11] that would provide guaranteed issue rights for people switching from Medicare Advantage to Traditional Medicare around the time of their birthday. Other states have bills pending that would offer "birthday rules" in their state – allowing people who currently have Medicare Supplement policies to switch policies around the time of their birthday including South Dakota[12] and Wisconsin.[13] None of these legislative efforts have been signed into law.

Federal Legislation

US Congress House Bill 610,[14] introduced in January of 2025, would require guaranteed issue and prohibit preexisting condition exclusions for new enrollees in Medicare Supplement plans.

H.R.3 - Elijah E. Cummings Lower Drug Costs Now Act (GovTrack, 2021) was introduced on April 22, 2021, in a previous session of Congress (but it did not receive a vote). Some provisions of this bill were incorporated into other bills, which included provisions that would have provided some guaranteed issue protections to Medicare beneficiaries, including requiring the one-time, 6-month Medicare Supplement plan open enrollment period to apply to all Medicare Supplement–

[5] https://www.legislature.ohio.gov/legislation/136/hb24.
[6] https://status.rilegislature.gov/.
[7] https://legiscan.com/RI/bill/H5499/2025.
[8] https://legiscan.com/NH/text/HB774/2025.
[9] https://legiscan.com/CA/text/SB1236/id/2989279.
[10] https://www.billtrack50.com/billdetail/1683212/17934.
[11] https://www.billtrack50.com/billdetail/1662609/3796.
[12] https://www.billtrack50.com/billdetail/1678521/17932.
[13] https://www.billtrack50.com/billdetail/1641836/.
[14] https://www.congress.gov/119/bills/hr610/BILLS-119hr610ih.pdf.

eligible beneficiaries, without regard to age (meaning it would apply to people under age 65 years). H.R.3 would also have provided a one-time opportunity for Medicare Advantage enrollees to switch to a Medicare Supplement plan, even if they had been in Medicare Advantage beyond the 1-year trial period. The Congressional Budget Office (CBO) estimated[15] that these provisions would increase Medicare spending by $14 billion over 10 years (2020-2029) (CBO, 2019). The CBO did not estimate the impact on Medicare Supplement premiums.

Other federal bills previously introduced would prohibit medical underwriting in Medicare Supplement plans at all times, except for people who qualify for Medicare on the basis of ESRD or would expand the initial federal guaranteed issue period to all Medicare beneficiaries, including those under age 65 years with disabilities, among other changes.

Back to Table of Contents

[15] https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf.

Background on Medicare

Created in 1965, Medicare is the federal health insurance program for people ages 65 years and over, regardless of income, medical history, or health status. Nationwide, more than 65 million people are covered by Medicare,[10] and more than 10% of them are in California. As of March 2023, more than 6.6 million California residents had Medicare coverage (CMS, 2024).

Medicare Financing

In 2021, Medicare benefit payments totaled $829 billion, up from $541 billion in 2011. Medicare is financed by general revenues (41% in 2017), payroll tax contributions (37%), beneficiary premiums (14%), and other sources[16] (Cubanski and Neuman, 2018).

Medicare Structure and Administration

CMS administers Traditional Medicare as a fee-for-service insurance program with few restrictions on access to care or choice of providers. The program was expanded in 1972 to cover certain people under age 65 years who have a long-term disability (KFF, 2019). This included extending Medicare benefits to cover the high cost of medical care for most individuals suffering from end-stage renal disease (ESRD).[17]

Medicare is modeled after private health insurance. Thus, Medicare covers *some* of the cost of some health care. Medicare Part A covers inpatient hospital stays, skilled nursing facility (SNF) stays, some home health visits, and hospice care. Part A benefits are subject to a deductible ($1,364 per benefit period in 2019). Part A also requires coinsurance for extended inpatient hospital and SNF stays.

Medicare Part B covers physician visits, outpatient services, preventive services, and some home health visits. Many Part B benefits are subject to a deductible ($257 in 2025),[18] and typically, coinsurance of 20%. No coinsurance or deductible is charged for an annual wellness visit or for preventive services that are rated 'A' or 'B' by the U.S. Preventive Services Task Force, such as mammography or prostate cancer screenings.

Because Traditional Medicare does not limit the maximum cost beneficiaries can incur for Part A and Part B covered services, 90% of Traditional Medicare beneficiaries obtain supplemental coverage. Many choose Part C, which refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO) and receive all Medicare-covered Part A and Part B benefits and typically also Part D benefits. Others choose Medicare Supplement plans, which wrap around Parts A and B.

Medicare Advantage plans are private health insurance plans paid by the federal government to provide Medicare-covered benefits as an alternative to "traditional" or "original" Medicare. Private plans have been available in Medicare since the 1970s, but enrollment in private plans remained relatively low through the 1990s. Aside from changing the name of Medicare private plans from Medicare+Choice to Medicare Advantage (also referred to as Medicare Part C), the Medicare Modernization Act of 2003 made significant changes that propelled enrollment growth (Ramsay et al., 2024).

In 2024, 32.8 million people were enrolled in a Medicare Advantage plan, accounting for more than half, or 54%, of the eligible Medicare population (Freed et al., 2024a). It offers an alternative to Traditional Medicare for health and drug

[16] The Medicare Trust Fund is a financial account in the U.S. Treasury that funds Medicare. There are two main trust funds: the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The Hospital Insurance Fund primarily covers inpatient hospital services (Medicare Part A), while the Supplementary Medical Insurance Trust Fund covers outpatient services and prescription drugs (Medicare Parts B and D).
[17] In October 1972, Section 299I of Public Law 92-603 created the National End Stage Renal Disease (ESRD) Program.
[18] https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles.

coverage and includes all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Part C may also offer additional coverage, such as: Vision, Hearing, Dental, Health and Wellness programs, and Medicare prescription drug coverage (Part D).

Part D Prescription Drugs

Part D, which went into effect in 2006, covers outpatient prescription drugs through private plans that contract with Medicare, including stand-alone prescription drug plans and Medicare Advantage plans with prescription drug coverage The Part D benefit helps pay for enrollees' drug helps pay for enrollees' drug costs for covered drugs. Additional financial assistance is available for beneficiaries with low incomes and modest assets.

Characteristics of Medicare Beneficiaries

Beneficiaries in Traditional Medicare with Medicare Supplement plans and employer-sponsored insurance had higher incomes, were in relatively good health, had more years of education, and were less likely to be under age 65 years with disabilities than all traditional Medicare beneficiaries. As more beneficiaries have shifted to Medicare Advantage plans, the number of Medicare beneficiaries in Traditional Medicare with no additional coverage has declined from 5.6 million in 2018 to 3.2 million in 2022. Traditional Medicare beneficiaries with no supplemental coverage were more likely to be under the age of 65 years and have relatively lower incomes compared to Traditional Medicare beneficiaries overall. Medicare Advantage enrollees were more likely to be Black or Hispanic, self-report relatively poor health, have incomes below $20,000 per person, and have lower levels of education, compared to Traditional Medicare beneficiaries in 2022 (Ochieng et al., 2024).

Table 2. When Medicare Supplement Plans Have Guaranteed Issue Protections Under Federal Law

Beneficiaries' Coverage Status	When a beneficiary has federally qualified guaranteed issue rights	When a beneficiary does not have federally qualified guaranteed issue rights
Has only Traditional Medicare	In the first 6 months of enrolling in Medicare Part B at age 65 years or older	After the first 6 months of enrolling in Medicare Part B
Has Traditional Medicare and an employer group retiree health plan or union coverage	If their employer cancels their retiree coverage	If their employer changes (but does not drop) retiree benefits If beneficiaries voluntarily drop retiree coverage
Has Traditional Medicare and Medicare Supplement	If beneficiary dropped a Medicare Supplement plan to join a Medicare Advantage plan (or to switch to a Medicare SELECT policy) for the first time, they've been in the plan less than a year, and want to switch back. This is referred to as "Trial Right."[19] If Medicare Supplement insurance company goes bankrupt or Medicare Supplement coverage ends through no fault of the beneficiary If Medicare Supplement insurance company commits fraud	If beneficiaries voluntarily drop Medicare Supplement plan coverage An exception is beneficiaries may suspend a Medicare Supplement plan for up to 2 years if they become eligible for Medicaid, in which case they have no new medical underwriting or waiting periods for pre-existing conditions when they restart their Medicare Supplement plan If current Medicare Supplement policyholders try to switch Medicare Supplement plans

[19] The trial right allows enrollees to disenroll from their MA plan during the first 12 months and return to Original Medicare.

Beneficiaries' Coverage Status	When a beneficiary has federally qualified guaranteed issue rights	When a beneficiary does not have federally qualified guaranteed issue rights
In a Medicare Advantage plan	If beneficiary joined a Medicare Advantage plan when they were first eligible for Medicare Part A at 65, and within the first year of joining, they decide to switch to Original Medicare. (There is also a 12-month period known as "Trial Right") If their plan withdraws from their area or if moving to a new area not covered by their plan If their Medicare Advantage plan is terminated If Medicare Advantage plan commits fraud	After 1 year of enrollment in any Medicare Advantage plan
Has Medicaid	None	In all cases
Other: under age 65 years in Medicare	None	In all cases However, when beneficiaries under age 65 years turn 65, they have the same time-limited federally guaranteed issue protections for Medicare Supplement plans as people aged 65 years and older, regardless of whether or not they had Medicare Supplement when they were under age 65

Source: California Health Benefits Review Program, 2025.

Back to Table of Contents

Impacts

As discussed in the *Introduction* section, SB 242 would require Medicare Supplement plans and policies regulated by the Department of Managed Health Care (DMHC) or the California Department of insurance (CDI) to offer two annual open enrollment periods for Medicare Supplement plan products, during which the insurance carriers would be prohibited from discriminating in the pricing of monthly premiums or denying applicants for pre-existing conditions due to age, applicant health status, claims experience, receipt of health care, or medical condition.

SB 242 is unlikely to impact Medi-Cal beneficiaries. Medicare enrollees who are also enrolled in Medi-Cal already get help with their out-of-pocket Medicare costs from Medi-Cal, where their Part B premiums and related cost sharing for Part B and the cost of benefits not covered by Medicare (e.g., vision, dental) are paid by Medi-Cal. Medicare enrollees who are dually enrolled in Medi-Cal are unlikely to purchase Medicare Supplement plan coverage because of this existing protection. There may be rare cases of dually eligible enrollees purchasing a separate Medicare Supplement plan, but it is likely cost-prohibitive for low-income Medi-Cal enrollees to purchase a Medicare Supplement on their own, given average premiums reach over $2,800 per year. Medicare beneficiaries who are also eligible for Medi-Cal can enroll in Medi-Cal at any time and do not need to sign up during a specific open enrollment period.

This section explains the potential impacts of SB 242 on estimated baseline premiums and enrollment in Medicare Supplement plans and policies. The predicted increases in Medicare Supplement plan premiums due to SB 242 are driven by what is commonly known as adverse selection and moral hazard. Adverse selection occurs when lower cost or healthier patients forgo buying insurance until they need it, while higher cost or sicker patients actively buy insurance to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase. A change in rules could also impact Medicare Supplement plan premiums if broadening guaranteed issue protections results in adverse selection in the Medicare Supplement plan market. There is evidence that Medicare Advantage enrollees with more health needs disenroll into Traditional Medicare at relatively higher rates, such as beneficiaries who have 2 or more complex chronic conditions or impairments in activities of daily living. If higher cost beneficiaries gain access to Medicare Supplement plans, premiums could rise (Meyers, et al.., 2019). Moral hazard refers to the risks that someone or something becomes more inclined to take because they have reason to believe that an insurer will cover the costs.

Analytic Approach and Key Assumptions

Bill Language

For this analysis, CHBRP has interpreted the bill language that postmandate, premiums for Medicare Supplement insurance will be community rated without regard for age of the applicant (i.e., does not vary by age), which contrasts with typical Medicare Supplement plan premium prices in California at baseline, which are based on attained age. In the context of health insurance, "community rating" means that everyone within a specific geographic area or community pays the same premium for a particular plan, regardless of their age, health status, or other individual factors.

CHBRP estimates that Medicare beneficiaries more likely to take advantage of the new open enrollment period, guaranteed issue coverage, and community-rated premiums are new enrollers with higher health care costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services. These newer enrollees fall into three groups:

- Traditional Medicare beneficiaries who did not purchase a Medicare Supplement plan during their first open enrollment period when entering Part B;

- Traditional Medicare beneficiaries who were denied Medicare Supplement plan coverage before or faced waiting periods or specific exclusions based on their individual characteristics (e.g., pre-existing conditions, receipt of health care, health status, age); and
- Medicare Advantage enrollees who signed up due to the added protection against high out-of-pocket spending.

Among those already in Traditional Medicare or Medicare Advantage, there is a group of eligible people who would benefit from the new, annual open enrollment opportunities because they could cancel their policy and decide not to purchase a Medicare Supplement plan (which is currently based on attained age). Medicare Advantage enrollees who initially signed up for Advantage for its added protection against high out-of-pocket spending, but have become dissatisfied (with either the network of providers available to them, prior approval requirements, or other restrictions on services imposed by their Advantage plan), could cancel their policy and decide *not* to purchase a Medicare Supplement plan and instead wait for a future open enrollment period to enroll.

Such enrollment decisions are not made in a vacuum. Once healthier people opt out and wait for actual health needs to occur before signing up, premiums for the Medicare Supplement plan market will increase due to the higher level of risk among those left in the market who are willing to sign up immediately. Once premiums increase, healthier, lower cost Medicare beneficiaries will cancel their Medicare Supplemental Insurance for two reasons:

- The premiums will increase, and they will decide they don't want to pay the higher premiums; or
- They could now purchase a guaranteed-issue policy during a future open enrollment period when they perceive a need for additional coverage. These people would be eligible for coverage but would save money by not enrolling and not paying premiums in a Medicare Supplement plan, whereas those enrolled in the Medicare Supplement plan postmandate would be those most likely to use services and incur cost sharing that would be covered by the Medicare Supplement plan or policy. The claims experience of enrollees in the Medicare Supplement plan would be more expensive than under current law, resulting in higher premiums for those enrolled in Medicare Supplement plans. Those higher premiums would act as a further impediment to healthy, lower cost people enrolling in Medicare Supplement plans or policies, resulting in further adverse selection and premium increases.

However, CHBRP has also factored in some enrollment shift into Medicare Supplement plans of enrollees with average health care costs due to dissatisfaction with Medicare Advantage plan networks and limitations on use of services, as many Medicare Advantage plans use HMO structures.

For the purpose of comparing the baseline Medicare Supplement plan market to the postmandate Medicare Supplement plan market, CHBRP has made the following analytic assumptions:

1) Premiums for Medicare Supplement plans will be community rated rather than based on the applicant's age when the policy is originally issued or based on attained age.[20] Current law prohibits discrimination by health status, claims experience, receipt of health care, or medical condition if a Medicare beneficiary applies during their initial open enrollment period or due to a qualifying event (e.g., moving into a new market). SB 242 would require the same premium pricing and denial prohibitions as in current law but expand their availability so that Medicare beneficiaries would have annual open enrollment opportunities. In addition, for new applicants during open enrollment, the premium offered to them by a Medicare Supplement plan would not vary by age. At baseline, Medicare Supplement plan premiums are priced based on the age of the applicant. Prohibiting age as a premium pricing factor would make the premium the same for anyone applying to a plan, regardless of age. This would increase the premiums paid by younger enrollees (closer to age 65 years) and decrease premiums paid by older enrollees.

2) The people most likely to enroll in a Medicare Supplement plan (postmandate), using the new open enrollment period, guaranteed issue coverage, and community rated premiums are new enrollees with higher health care

[20] Community rating without regard to attained age would further increase adverse selection, which would increase premiums more than the estimates provided in this report. If pure community rating were used, everyone would be charged the same premium regardless of age at issue, or age at application.

costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services.

3) CHBRP estimated that 14% of current Medicare Supplemental Insurance policyholders would leave the Medicare Supplemental plan market in 2026 (Ortner, 2022). Ortner (2022) analyzed the impact of community rating on Medicare Supplement plans in Washington State and estimated that the 16% increase in premiums caused by the shift to community rating would result in the disenrollment of 7% of the current market. However, the report did not predict the impact of new, higher cost enrollees joining the community rated market during the extended open enrollment period. CHBRP assumed that the disenrollment impact would be a bit higher (8%) than predicted in Washington, given the likely larger increases in premiums due to lower cost people disenrolling and higher cost applicants securing community rated coverage. The previous enrollees (who were enrolled in Medicare Supplement plans at baseline and dropped coverage) would save money by not paying premiums in a Medicare Supplement plan, whereas those enrolled in Medicare Supplement plans would be those most likely to use services and incur cost sharing that would be covered by the Medicare Supplement plan. The claims experience of enrollees in the Medicare Supplement plan would be higher than under current law, resulting in higher premiums for those enrolled in the Medicare Supplement. Those higher premiums would act as a further impediment to healthy, lower cost people enrolling in the policy, resulting in further adverse selection and premium increases. That said, CHBRP estimates a portion of "slightly-healthier-than-average-cost" members in Medicare Advantage will take this opportunity to move to Traditional Medicare with a Medicare Supplement plan. The rationale for these members to move are frustrations with provider network limitations and the potential reduction of supplemental benefits in the MA market.

4) SB 242 would also allow patients with end-stage renal disease (ESRD) to enroll in Medicare Supplement plans. Although the population is small, these members have high medical needs and could benefit from enrolling in a Medicare Supplement plan. CHBRP did not make any explicit assumptions around ESRD members, but did include them in the analysis.

5) CHBRP assumed no additional utilization of services would occur due to new enrollment in Medicare Supplement plan coverage. Given the Medicare Supplement plan applicants and enrollees already have existing Medicare coverage, CHBRP focused on the cost sharing that Medicare Supplement plans would pay for if a Medicare beneficiary obtained new supplemental coverage due to SB 242.

6) Of all Medicare enrollees without supplemental coverage (in both Traditional Medicare Parts A/B or in Medicare Advantage), approximately 7.5% of the enrollees with high health care spending or high-need clinical conditions would opt into a Medicare Supplement plan during the next open enrollment period postmandate for 2026. A small portion of Medicare beneficiaries would opt to change their Medicare Advantage (10%) or Part D Prescription Drug plan (21%) each year, and CHBRP anticipates that most enrollees will maintain their baseline Medicare Supplement enrollment status (Fuglesten Biniek et al., 2022). The high-need clinical conditions are skilled nursing service use (2.7% of Medicare beneficiaries), lymphoma (1.8%), leukemia (0.3%), and lung cancer (1.4%). High health care spending was defined as spending more than $10,000 (1.9%) each year.[21]

7) CHBRP assumes that the current range of Medicare Supplement plan options offered by insurance carriers in California will continue to be available in 2026. CHBRP does not estimate the impact of insurance carrier exits from the Medicare Supplement plan market in 2026 due to SB 242.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

[21] The prevalence of high-need clinical conditions and high health care spending was calculated based on the Medicare 5% National Sample file from the Centers for Medicare & Medicaid Services (CMS) Standard Analytical Files of Medicare Claims.

Baseline and Postmandate Enrollment and Premiums

Below, Table 3 provides projected information on the impacts on Medicare Supplement plan enrollment, claim costs, and premiums in 2026. CHBRP estimates that the number of enrollees in Medicare Supplement plans and policies will decrease by 6,400 (−1%) postmandate (see Table 3). Overall, the average monthly premiums for Medicare Supplement plans and policies will increase by $40.00 (14%) per member per month (PMPM) due to SB 242.

Table 3. Impacts on Medicare Supplement Plan Enrollment, Claim Costs, and Premiums, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Enrollment numbers				
Medicare Supplement plans	1,134,309	1,127,909	−6,400	−1%
Medicare Advantage or Original Medicare without Medicare Supplement	4,261,214	4,267,614	6,400	0%
Claim costs and premiums				
2026 Average monthly claim costs Medicare Supplement plan market, PMPM	$232.52	$266.07	$33.56	14%
2026 Average monthly premiums Medicare Supplement plan market, PMPM	$277.14	$317.13	$40.00	14%

Source: California Health Benefits Review Program, 2025.
Note: Enrollment figures exclude members enrolled in Medi-Cal.
Key: PMPM = per member per month.

CHBRP's estimates are to CHBRP's projection that new enrollees in Medicare Supplement plans will use more services than the average enrollee at baseline. The new entrants to the Medicare Supplement plan market are likely to be higher cost enrollees, and they will displace lower cost enrollees who find it advantageous to disenroll from their Medicare Supplement plan rather than pay higher premiums to continue their coverage. The new entrants will include people who were denied Medicare Supplement plan coverage in the past, or faced waiting periods or specific exclusions, who will have a new opportunity to enroll when the new open enrollment opportunities are expanded by SB 242. Note: these estimates are lower than those in the CHBRP analysis of bill AB 1236 last year because based on additional studies from other states, we have reduced the estimated disenrollment to 8% from last year's estimate of 14%, lowered the assumed shift of high cost cohorts to 7.5% from 20%, and also included the assumption of members leaving Medicare Advantage plans for Medicare Supplement plans due to network frustrations.

In addition, CHBRP expects that some high-cost, high-need patients may be in Medicare Advantage plans currently but will move to Traditional Medicare with a Medicare Supplement to improve their ability to seek out care from more providers that may not be in their current Medicare Advantage network. Some slightly healthier than average cost enrollees currently in Medicare Advantage plans are also expected to take this opportunity to move to traditional Medicare with a Medicare Supplement plan in order to improve their access to specific networks of physicians and hospitals.

Adverse Selection

In general, whenever consumers can choose whether to purchase health insurance or which plans they would like to enroll in, those expecting to have high medical expenses tend to be more likely to purchase coverage or enroll in a higher cost plan with more protective benefits, a phenomenon called "adverse selection." Because premiums reflect the projected medical spending by all of those who have purchased coverage, adding more expensive beneficiaries—via adverse selection—will increase average costs and raise premiums. Medicare Advantage beneficiaries using more services are more likely to resist restrictions on their care arising from limited provider networks—such as cancer patients not being able to see the oncologist of their choice—or use management requirements—such as requiring prior authorization before covering an expensive drug or procedure. As a result, it is likely that those Medicare Advantage plan enrollees who want to enroll in Medicare Supplement plan when switching to Traditional Medicare are using more medical services than average Medicare Advantage beneficiaries. To the extent that this is the case, guaranteed issue would increase Medicare Supplement plan premiums, a potential reason most states do not require it.

The expected increase in Medicare Supplement plan premiums from assuring that Medicare Advantage plan enrollees who switch to Traditional Medicare can access affordable Medicare Supplement coverage would depend on the degree of adverse selection. It would also depend on the number of beneficiaries who, when switching to Traditional Medicare, enroll in Medicare Supplement compared to the number of overall Medicare Supplement enrollees. The degree of adverse selection for those switching to Traditional Medicare would likely increase if beneficiaries leaving Medicare Advantage had assured access to affordable Medicare Supplement coverage. A study of disenrollment from Medicare Advantage analyzing 2014 and 2015 data found that only 3.7 percent (0.5 million) of 13.9 million Medicare Advantage beneficiaries switched to Traditional Medicare, but high-need and dually eligible beneficiaries had substantially higher rates of switching than Medicare-only, non–high-need beneficiaries (Meyers et al, 2019).

Improved access to Medicare Supplement would also lead to more beneficiaries switching to Traditional Medicare, increasing the percentage of switchers in the Medicare Supplement pool. Estimating how much and for how many years the expected spending of Medicare Advantage switchers would remain above average poses an additional complication in accounting for their effects on Medicare Supplement premiums.

Subgroup Analysis

Examples are provided below to illustrate how certain enrollees would experience the impacts of SB 242 differently. The changes described above in Table 4 reflect the relative claims experience of many Medicare beneficiaries who first enroll in Medicare Supplement plans at age 65 years when they initially enroll in Medicare, in comparison to applicants who have been unable to access Medicare Supplement insurance coverage due to pre-existing conditions, or higher premiums based on health status, use of health care services, or age.

All subgroup examples are based on a simplifying assumption that enrollees (or applicants) are in the individual Medicare Supplement plan market. At baseline, people who newly qualify for Medicare use the open enrollment period to enroll in a Medicare Supplement plan at a lower-than-average monthly premium. These enrollees will typically stay in Medicare Supplement plans and policies in the long term, due to their perceived risk at enrollment or because the Medicare Supplement plan premium will offset their likely cost sharing each year. Postmandate, some of these enrollees with few high-cost needs will exit the market due to a 98% increase in premiums for their age and health status. Baseline, their premium would have been $160 per month based on their initial age at application of 67 years, and premiums based on attained age. However, the shift to pure community rating would mean that all applicants would be offered the same premium without regard to age, increasing the premium to $317.13. Due to their comparatively good health status, and the perception that they could come back to the market in the future through open enrollment without penalty will result in them disenrolling or turning down the Medicare Supplement plan due to cost.

By contrast, applicants with skilled nursing needs, cancer diagnoses, or other high-cost needs who face barriers to enrolling in the premandate Medicare Supplement plan insurance market due to the restricted open enrollment periods, pre-existing condition exclusions, waiting periods, and initial premiums will be allowed to enroll in Medicare Supplement plans postmandate. The higher postmandate premiums ($317.13 on average per month) are lower than the expected out-of-pocket spending the enrollee would expect without Medicare Supplement plan coverage.

Table 4. Summary of Assumed Enrollee Migration From SB 242

Cohorts	Enrollment	Avg. Med Supp Claim Costs
Medicare Supplement plan enrollee – **Baseline**	1,134,309	$232.52
Number moving into Med Supp – nursing home	8,500	$1,134.20
Number moving into Med Supp – lymphoma	5,800	$494.29
Number moving into Med Supp – leukemia	1,100	$658.50
Number moving into Med Supp – lung cancer	4,500	$940.92
Number moving into Med Supp – other high cost	6,000	$1,988.34
Number moving into Med Supp – MA network frustration	58,400	$133.07
Number moving out of Med Supp – due to premium increases	(90,700)	$8.89
Medicare Supplement plan enrollee – **Postmandate**	1,127,909	$266.07

Source: California Health Benefits Review Program, 2025.
Key: MA = Medicare Advantage and Med Supp = Medicare Supplement plan.

The overall number of enrollees in Medicare Supplement plans in California will decrease by 6,400 postmandate. A total of 90,700 enrollees at baseline would disenroll from their coverage postmandate due to increases in premiums, while there are 84,300 new enrollees who will enroll in Medicare Supplement plans postmandate. The new enrollees are in two buckets: 1) About 25,900 will have higher needs and higher costs than their existing enrollees postmandate, while 2) about 58,400 will have a little healthier than average needs and costs. At baseline, the average claim costs for Medicare Supplement plan enrollees were $232.52 per month. Postmandate, that number increases to $266.07 per month on average, driven by: 1) a relatively small group of enrollees (25,900) moving into Medicare Supplement plan coverage with higher claims (ranging from $494.29 per month in spending by lymphoma patients to $1,988.34 per month in spending from other high-cost patients); and 2) people who are likely to exit the Medicare Supplement plan market completely are lower cost enrollees, with $8.89 in average claims per month (Table 4). The increase in premiums is dampened slightly by slightly healthier than average cost members moving into Medicare Supplement plans who are anticipated to have monthly claim costs of $133.07.

Individual Examples

Examples are provided below to illustrate how certain enrollees would experience the impacts of SB 242 differently.

In Example 1, CHBRP provides a scenario faced by a 67-year-old who had already enrolled in a Medicare Supplement plan at open enrollment when they had turned 65 and enrolled in Traditional Medicare. At baseline, the enrollee would pay $160 per month based on their attained age of 67 years for a total of $1,920 per year. Their actual cost sharing not covered by their Medicare Supplement plan is only $275 per year (this is the assumed 2026 Part B deductible, which cannot be covered by Medicare Supplement) (Medicare, 2024). Postmandate, because higher cost applicants would enroll in Medicare Supplement and premiums would be the same for everyone enrolled in the plan regardless of age, the premium paid by the 67-year-old enrolled at baseline would increase by $1,890 per year (98%).

Example 1. Healthy 67-Year-Old Enrolled in a Medicare Supplement Plan (Illustrative)

Category	Baseline	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Annual premiums	$1,920	$3,810	$1,890	98%
Annual cost sharing	$275	$275	—	0%
Total patient costs	$2,195	$4,085	$1,890	86%

Source: California Health Benefits Review Program, 2025.
Notes: Assumes member is enrolled in Plan G postmandate.
Assumes baseline premiums of $160/month and a postmandate premium of $317.

Example 2 provides a profile of an applicant who is enrolled in Traditional Medicare with no supplemental coverage and is being treated for cancer. At baseline, they do not pay any premiums because they cannot find a Medicare Supplement plan that will accept them with their cancer diagnosis, resulting in $11,600 in out-of-pocket spending related to use of their Traditional Medicare (Part A/B) benefits. In Traditional Medicare, there is no out-of-pocket maximum, and in Part B, coinsurance is 20%. Postmandate, the ability to enter the Medicare Supplement plan market and enroll in a plan would save the 67-year-old cancer patient $7,515 per year (65%) overall because their out-of-pocket spending related to cost sharing would decrease by $11,325 per year, and their premiums for a Medicare Supplement plan would be $3,810 per year. In this example, the limits of a Medicare Advantage plan's provider network may mean that a Medicare Supplement plan is a more attractive option for the enrollee.

Example 2. Cancer Patient 67-Year-Old Enrolled in Original Medicare (Illustrative)

Category	Baseline	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Annual premiums	—	$3,810	$3,810	N/A
Annual cost sharing	$11,600	$275	$(11,325)	−98%
Total patient costs	$11,600	$4,085	$(8,515)	−65%

Source: California Health Benefits Review Program, 2025.
Notes: Assumes member is enrolled in Plan G postmandate.
Assumes baseline premiums of $160/month and a postmandate premium of $317.

In Example 3, CHBRP provides a scenario faced by a 75-year-old who had already enrolled in a Medicare Supplement plan at open enrollment when they had turned 65 and enrolled in Traditional Medicare. At baseline, the enrollee would pay $210 per month based on their attained age of 75 years for a total of $2,520 per year. Their actual cost sharing covered by their Medicare Supplement plan is $275 per year (this is the assumed Part B deductible, which cannot be covered by the Medicare Supplement plan) (Medicare, 2024). Postmandate, because higher cost applicants would enroll in Medicare Supplement and premiums would be the same for everyone enrolled in the plan regardless of age, the premium paid by the 75-year-old enrolled at baseline would increase by $1,290 per year (51%).

Example 3. Healthy 75-Year-Old Enrolled in a Medicare Supplement Plan (Illustrative)

Category	Baseline	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Annual premiums	$2,520	$3,810	$1,290	51%
Annual cost sharing	$275	$275	—	0%
Total patient costs	$2,795	$4,085	$1,290	46%

Source: California Health Benefits Review Program, 2025.
Notes: Assumes member is enrolled in Plan G postmandate.
Assumes baseline premiums of $210/month and a postmandate premium of $317.

Example 4 provides a profile of a 75-year-old applicant who is enrolled in Traditional Medicare with no supplemental coverage and is being treated for cancer. At baseline, they do not pay any premiums because they cannot find a Medicare Supplement plan that will accept them with their cancer diagnosis, resulting in $11,600 in out-of-pocket spending related to use of their Traditional Medicare (Part A/B) benefits. In Traditional Medicare, there is no out-of-pocket maximum, and in Part B, coinsurance is 20%. Postmandate, the ability to enter the Medicare Supplemental plan market and enroll in a plan would save the 75-year-old cancer patient $7,515 per year (65%) overall because their out-of-pocket spending related to cost sharing would decrease by $11,325 per year, and their premiums for a Medicare Supplement plan would be $3,810

per year. In this example, the limitations of a Medicare Advantage plan's provider network may mean that a Medicare Supplement plan is a more attractive option for the enrollee. Example 4 looks identical to Example 2 because the age of applicant does not matter in a community-rated insurance market, so both beneficiaries save the same amount due to being denied from purchasing Medicare Supplement plan coverage at baseline.

Example 4. Cancer Patient 75-Year-Old Enrolled in Original Medicare (Illustrative)

Category	Baseline	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Annual premiums	—	$3,810	$3,810	N/A
Annual cost sharing	$11,600	$275	$(11,325)	−97%
Total patient costs	$11,600	$4,085	$(7,515)	−65%

Source: California Health Benefits Review Program, 2025.
Notes: Assumes member is enrolled in Plan G postmandate.
Assumes baseline premiums of $200/month and a postmandate premium of $286.

In all four examples, baseline premiums in the Medicare Supplement insurance market are based on attained age of the applicant. Due to open enrollment, guaranteed issue, and pure community rating requirements, the two healthier examples (Examples 1 and 3) will see their premiums increase substantially, while those who were kept out of the market before due to their cancer diagnoses will save money because the cost of their premiums under SB 242 will be less than their out-of-pocket spending at baseline.

Postmandate Administrative Expenses and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums. In the Medicare Supplement plan market, the portion of the premium attributable to administrative costs, overhead, profit, and other nonmedical sources of spending is roughly 20%.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Changes in Public Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 242. The number of enrollees in Medicare overall would not change due to SB 242. However, there will be a reduction in the number of enrollees who have Traditional Medicare with supplemental coverage due to the change to open enrollment processes and premium pricing practices.

Availability of Medicare Policies

It is possible that SB 242 would result in insurers closing enrollment in the Medicare Supplement plan market in California due to the expanded open enrollment period and community-rated premiums, resulting in less competition and potentially higher premiums. California requires the renewal of existing insurance policies. Therefore, closing enrollment does not mean that existing enrollees would lose their coverage immediately, just that there could be no new entrants. However, the renewed policy would need to comply with the new "pure" community rating rules for pricing premiums.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of SB 242, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature.

Premiums would likely increase in the Medicare Supplement plan insurance market as a result of SB 242. The change in premium rating rules and open enrollment processes would allow Medicare beneficiaries with high expected cost sharing to join a Medicare Supplement plan when their perceived risk is highest and allow healthier people who are not yet using lots of Medicare services to wait until their perceived risk is highest before entering the market. Therefore, the 14% premium increase estimated in Table 3 could be an underestimate over time given the assumption that 7.5% of enrollees with skilled nursing needs, cancer diagnosis, or more than $10,000 in claims would enroll in a Medicare Supplement plan in 2026 and that 8% of current enrollees in Medicare Supplement plans would leave their plans. If all potential “high-cost” applicants decided to enroll in a Medicare supplement plan to address their perceived cost-sharing risk each year, premiums would roughly double as lower cost people exit the market and higher cost enrollees enter. This demonstrates that the estimated premium increase is highly dependent upon the chosen assumptions. However, based on current market conditions and the assumption that 7.5% of higher cost or higher need applicants would enroll in a plan, it is likely that an equilibrium will be established in the Medicare Supplement plan around the estimated premium increase of 14% stated in this report.

The strong presence of integrated Medicare Advantage health maintenance organizations (HMOs) with organized provider networks may blunt the long-term impacts such that not all eligible applicants would take advantage of an open enrollment period to obtain a Medicare Supplement plan over time. Medicare Advantage plans offer out-of-pocket maximums, limits on cost sharing, and other benefits that are attractive to their enrollees when paired with an adequate network of providers. A majority (55%) of California’s Medicare Beneficiaries are enrolled in Medicare Advantage plans (KFF, 2023). This makes Medicare Advantage an attractive option for enrollees who do not wish to sign up for a Medicare Supplement plan upon initial Medicare enrollment, as the Medicare Advantage plans generally provide robust benefits, out-of-pocket spending protection, and comprehensive provider networks.

As mentioned above, over the long term, SB 242 could result in fewer insurers willing to participate in the Medicare Supplement plan market in California. This could result in fewer options for Medicare beneficiaries to choose from in California. However, fewer plans could create less churn by creating a more stable enrollment base spread among a smaller number of carriers over time.

Back to Table of Contents

Appendix A. Text of Bill Analyzed

On February 19, 2025, the California Senate Committee on Health requested that CHBRP analyze SB 242, as introduced on January 30, 2025.

Below is the bill language, as it was introduced on January 30, 2025.

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

SENATE BILL

NO. 242

Introduced by Senator Blakespear
(Coauthors: Senators Archuleta, Limón, Stern, and Umberg)
(Coauthors: Assembly Members Addis, Bauer-Kahan, Garcia, Mark González, Ortega, Schiavo, and Zbur)

January 30, 2025

An act to amend Section 1358.11 of, and to add Section 1358.25 to, the Health and Safety Code, and to amend Section 10192.11 of, and to add Section 10192.25 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 242, as introduced, Blakespear. Medicare supplement coverage: open enrollment periods.

Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing federal law additionally provides for the issuance of Medicare Supplement plan policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Existing law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Existing law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare Supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application 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 benefits under Medicare Part B. Existing law requires an issuer to make available specified Medicare Supplement benefit

plans to a qualifying applicant under those circumstances who is 64 years of age or younger who does not have end stage renal disease.

This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The bill, on and after January 1, 2026, would prohibit an issuer of Medicare Supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare Supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare Supplement plan coverage available from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period.

Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

---

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares as follows:

(a) Existing state law requires insurance companies that sell Medicare supplement coverage, also known as Medigap coverage, to issue that insurance on a guaranteed-issue basis to eligible individuals without adjusting premiums based on medical underwriting, as long as their applications are submitted within a one-time open enrollment period.

(b) The open enrollment period in the state is during the six-month window beginning when the individual is enrolled for benefits under Medicare Part B. After this open enrollment period, there is no guarantee that Medigap coverage will be issued to individuals with preexisting medical conditions unless the individual satisfies certain conditions, and even if the coverage is issued, the premium may be significantly higher.

(c) As a result, it is extremely difficult for individuals whose health conditions or financial situations may have changed after their open enrollment period to switch to another Medicare supplement coverage plan that is more suitable.

(d) It is, therefore, the intent of the Legislature in enacting this act to do both of the following:

> (1) Establish an annual open enrollment for applicants, and require Medigap coverage issuers in California to accept an individual's application for coverage or an application to switch to another eligible plan during that period.

(2) Prohibit issuers from denying the applicant Medigap coverage or making any premium rate distinctions due to any of the following:

(A) Health status.

(B) Claims experience.

(C) Medical condition.

(D) Whether the applicant is receiving health care services.

SEC. 2. Section 1358.11 of the Health and Safety Code is amended to read:

1358.11. (a) (1) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a contract that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) (A) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision, who is 64 years of age or ~~younger, and who does not have end-stage renal disease.~~ *younger.* An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(B) For contracts sold or issued on or after January 1, 2020, to newly eligible Medicare beneficiaries, as defined in subdivision (b) of Section 1358.92, an issuer shall make available Medicare supplement benefit plans A, B, D, and G, if currently available, to applicants who qualify under this subdivision who are 64 years of age or ~~younger and who do not have end-stage renal disease.~~ *younger.* An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(3) This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.

(c) Except as provided in subdivision (b) and Section 1358.23, subdivision (a) does not prevent the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of their enrollment in Medicare Part B, or if notified retroactively of their eligibility for Medicare, for six months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, including coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included covered persons.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g) (1) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare Advantage plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h) (1) An individual shall be entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, an issuer that falls under this paragraph shall not deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of their rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period, and on any notice related to a benefit modification or premium adjustment.

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

(A) A 1990 standardized Medicare supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan A.

(B) A 1990 standardized Medicare supplement benefit plan B shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan B.

(C) A 1990 standardized Medicare supplement benefit plan C shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan C.

(D) A 1990 standardized Medicare supplement benefit plan D shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(E) A 1990 standardized Medicare supplement benefit plan E shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan D.

(F) (i) A 1990 standardized Medicare supplement benefit plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(G) A 1990 standardized Medicare supplement benefit plan G shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(H) A 1990 standardized Medicare supplement benefit plan H shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(I) A 1990 standardized Medicare supplement benefit plan I shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(J) (i) A 1990 standardized Medicare supplement benefit plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(K) A 1990 standardized Medicare supplement benefit plan K shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan K.

(L) A 1990 standardized Medicare supplement benefit plan L shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan L.

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

(i) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements:

(1) They are no longer eligible for Medi-Cal benefits.

(2) They are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

SEC. 3. Section 1358.25 is added to the Health and Safety Code, to read:

1358.25. (a) On and after January 1, 2026, an issuer of Medicare supplement coverage in this state shall not deny or condition the issuance or effectiveness of any Medicare supplement coverage contract available for sale in the state, or discriminate in the pricing of the contract because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for that coverage is submitted at either of the following times:

(1) Before or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B, as described in subdivision (a) of Section 1358.11.

(2) During an annual open enrollment period, including, but not limited to, the open enrollment period established in subdivision (b).

(b) (1) An individual enrolled in Medicare Part B is entitled to a 90-day annual open enrollment period beginning on January 1 of each year, as described in this section.

(2) During the open enrollment period established pursuant to this subdivision, applications shall be accepted for any Medicare supplement coverage available from an issuer.

(3) The open enrollment period established pursuant to this section is a guaranteed issue period.

SEC. 4. Section 10192.11 of the Insurance Code is amended to read:

10192.11. (a) (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, 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 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. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) (A) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision, who is 64 years of age or ~~younger, and who does not have end-stage renal disease.~~ *younger.* An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(B) For policies sold on or after January 1, 2020, to newly eligible Medicare beneficiaries, as defined in subdivision (b) of Section 10192.92, an issuer shall make available Medicare supplement benefit plans A, B, D, and G, if currently available, to applicants who qualify under this subdivision who are 64 years of age or ~~younger and who do not have end-stage renal disease.~~ *younger.* An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement benefit plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

(3) This section and Section 10192.12 do not prohibit an issuer in determining premium rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification. This section does not

prevent the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10192.8 or paragraph (1) of subdivision (a) of Section 10192.81.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the commissioner.

(c) Except as provided in subdivision (b) and Section 10192.23, subdivision (a) does not prevent the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of their enrollment in Medicare Part B, or if notified retroactively of their eligibility for Medicare, for six months following notice of eligibility. Every issuer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that issuer at the time of application. An issuer shall not discourage sales during the open enrollment period by any means, including the altering of the commission structure.

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses, including, but not limited to, coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(g) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by a Medicare supplement issuer and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

(h) (1) An individual shall be entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, an issuer that falls under this paragraph shall not deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. An issuer shall notify a policyholder of their rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period, and on any notice related to a benefit modification or premium adjustment.

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

(A) A 1990 standardized Medicare supplement benefit plan A shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan A.

(B) A 1990 standardized Medicare supplement benefit plan B shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan B.

(C) A 1990 standardized Medicare supplement benefit plan C shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan C.

(D) A 1990 standardized Medicare supplement benefit plan D shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(E) A 1990 standardized Medicare supplement benefit plan E shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan D.

(F) (i) A 1990 standardized Medicare supplement benefit plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan F shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(G) A 1990 standardized Medicare supplement benefit plan G shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(H) A 1990 standardized Medicare supplement benefit plan H shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan D.

(I) A 1990 standardized Medicare supplement benefit plan I shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan G.

(J) (i) A 1990 standardized Medicare supplement benefit plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan F.

(ii) A 1990 standardized Medicare supplement benefit high deductible plan J shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit high deductible plan F.

(K) A 1990 standardized Medicare supplement benefit plan K shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan K.

(L) A 1990 standardized Medicare supplement benefit plan L shall be deemed to offer benefits equal to those provided by a 2010 standardized Medicare supplement benefit plan L.

(M) New or innovative benefits, as described in subdivision (f) of Section 10192.9 and subdivision (f) of Section 10192.91, shall not be included when determining whether benefits are equal to or lesser than those provided by the previous coverage.

(i) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements:

(1) They are no longer eligible for Medi-Cal benefits.

(2) They are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

SEC. 5. Section 10192.25 is added to the Insurance Code, to read:

10192.25. (a) On and after January 1, 2026, an issuer of Medicare supplement coverage in this state shall not deny or condition the issuance or effectiveness of any Medicare supplement coverage policy or certificate available for sale in the state, or discriminate in the pricing of the policy or certificate because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for that coverage is submitted at either of the following times:

(1) Before or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B, as described in subdivision (a) of Section 10192.11.

(2) During an annual open enrollment period, including, but not limited to, the open enrollment period established in subdivision (b).

(b) (1) An individual enrolled in Medicare Part B is entitled to a 90-day annual open enrollment period beginning on January 1 of each year, as described in this section.

(2) During the open enrollment period established pursuant to this subdivision, applications shall be accepted for any Medicare supplement coverage available from an issuer.

(3) The open enrollment period is a guaranteed issue period.

SEC. 6. 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.

Appendix B. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

Analysis-Specific Data Sources

For this analysis, CHBRP relied on CPT codes to identify services related to SB 242. CPT copyright 2025 American Medical Association. All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

Five Percent Sample Data

CHBRP estimated costs and membership information for enrollees in the California Medicare population using the 2022 Medicare 5% Standard Analytic Files (SAF). These files contain membership and cost information for a sample of enrollees in the Original Medicare population.

Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

The analysis of SB 242 was developed using assumptions around the cost of Medicare Supplement plans' premiums and claims cost in California and cost and membership information for cohorts that may enroll in or leave Medicare Supplement plans due to this proposed legislation.

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is almost certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Notably, there is significant uncertainty in how enrollees will react to changes in the Medicare Supplement product offering. Additionally, the projections in this report are more sensitive to certain assumptions than to others. Particularly, the 7.5% assumption of population cohorts moving into Medicare Supplement plans and the 8% assumption of Medicare Supplement members canceling their policies are two of the assumptions that the results are most sensitive to. Therefore, the actual impact of SB 242 could vary significantly from the projections made in this report.

Methodology and Assumptions for Baseline Population

- The population subject to the mandated offering includes individuals eligible for Medicare Supplement plans in California. CHBRP made the following assumptions about the population that SB 242 could impact:
    - **Medicare Supplement enrollees** – CHBRP estimated the number of enrollees currently in Medicare Supplements through the California Department of Insurance (CDI) using the number of covered lives from the "2023 Medicare Supplement Loss Ratios[22]" report by the National Association of Insurance

[22] https://content.naic.org/sites/default/files/publication-med-bb-medicare-loss-report.pdf.

Commissioners (NAIC) along with the number of enrollees currently in Medicare Supplements through the Department of Managed Health Care (DMHC) as of 2023. CHBRP assumed no enrollment trend between 2023 and 2026.

- **Medicare eligibles not enrolled in Medicare Supplement** – CHBRP estimated the population not enrolled in Medicare Supplement using 2021 non-dual eligible enrollment from the California Department of Health Care Services (DHCS)'s report "Profile of the California Medicare Population: February 2022[23]". CHBRP assumed an annual growth in enrollment of 0.0% between 2021 and 2026, which was informed by observed trend seen in the Medicare Monthly Enrollment[24] files from the Centers for Medicare and Medicaid Services (CMS).

- CHBRP estimated average Medicare Supplement plan premiums using California specific premium rates from the NAIC "2023 Medicare Supplement plan Loss Ratio" report (NAIC, 2023) and informed by recent rate filings. CHBRP trended 2023 premiums to 2026 using an annual trend rate of about 7.2%.

- CHBRP assumed baseline claims costs were 83.9% of baseline premium costs. These were based on a nationwide loss ratio of 83.9% reported in the NAIC report.

Methodology and Assumptions for Interested Population Cohorts

- CHBRP assumed that the people most likely to take advantage of the new open enrollment period, guaranteed issue coverage, and attained age-based premium rating were those with higher health care costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services. CHBRP used the 2022 Medicare 5% SAF to identify the prevalence and average patient cost sharing for members covered in the Medicare fee-for-service population for medical services only.

  - **Lymphoma** – Non–dual-eligible enrollees with at least one diagnosis code starting with "C81 – C85" during 2022 or who were assigned HCC (Hierarchal Cost Condition) 10 under the CMS HCC 20 risk score model. CHBRP estimated the prevalence to be 1.8%.

  - **Leukemia** – Non–dual-eligible enrollees with at least one diagnosis code starting with "C91 – C95" during 2022. CHBRP estimated the prevalence to be 0.3%.

  - **Lung Cancer** – Non–dual-eligible enrollees with at least one diagnosis code starting with "C34" during 2022 or who are assigned HCC 9 under the CMS HCC 20 risk score model. CHBRP estimated the prevalence to be 1.4%.

  - **Nursing Home Patients** – Non–dual-eligible enrollees who had at least one professional CPT code beginning with "993" during 2022. CHBRP estimated the prevalence to be 2.7%

  - **Other High-Cost Patients** – Other non–dual-eligible enrollees with greater than $10,000 in cost sharing during 2022, with an adjustment intended to exclude the other patient types above. Since SB 242 considers Medicare Supplement plans, we did not consider cost sharing for prescription drugs (e.g., Medicare Part D) claims in determining which enrollees exceeded this threshold. CHBRP estimated the prevalence to be 1.9%.

- CHBRP assumed the prevalence of these members in the general 2026 Medicare population matched the 2022 Medicare 5% sample. The average patient pay for each of these member cohorts was trended to 2026 using an annual trend of 7%.

[23] https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-18-2022.pdf.
[24] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data.

- In calculating the prevalence and average patient cost sharing of these cohorts, CHBRP included ESRD members in the calculations. This was a difference between SB 242 and the SB 1236 analysis from last year.

Methodology and Assumptions for Population Shifts

- CHBRP assumed that 7.5% of each of the enrollee cohorts described in the "Methodology and Assumptions for Interested Population Cohorts" would enroll in Medicare Supplement plans because of SB 242.
- CHBRP assumed that some enrollees may cancel their Medicare Supplement plan because of SB 242 either because 1) premiums will increase and they will decide they don't want to pay the higher premiums or 2) they can disenroll now and later purchase a guaranteed-issue policy during a future enrollment period when they perceive a need for the additional coverage. CHBRP made the following assumptions about these members:
    - **Prevalence:** CHBRP assumed that this cohort of enrollees represents 8% of the current Medicare Supplement plan population informed by the "Washington State Medicare Supplemental Insurance Study[25]" from 2022. We are using a slightly higher percentage than that report because SB 242 will also change the rating to community rated (Washington State is already community rated), which will increase the premiums for younger people.
    - **Patient Cost Sharing:** CHBRP estimated the patient cost sharing for this population as the 25th percentile of non-dual eligible enrollee cost sharing seen in the 2022 Medicare 5% SAF. This was trended from 2022 to 2026 using an annual trend rate of 7%.
- CHBRP assumes that 2% of enrollees Medicare Advantage plans will take this opportunity to leave their Medicare Advantage plan and enroll in a Medicare Supplement plan. CHBRP assumes that these enrollees will be a little healthier than average.

Methodology and Assumptions for Premium Impact

- All members moving into Medicare Supplement plan from other coverages were assumed to enroll into Plan G, which is the richest Medicare Supplement plan covering all cost sharing except for the Part B deductible. Therefore, the Medicare Supplemental plan claim costs for these members were assumed to be their trended patient cost sharing for medical services less the Part B deductible. CHBRP assumed the 2026 Part B deductible to be $275.
    - Similarly, any member leaving the Medicare supplemental market was assumed to disenroll from Plan G.
- After using the assumptions above to estimate the claim cost impact in the Medicare Supplement plan market, CHBRP assumed an 83.9% loss ratio to estimate the premium impact.
- The estimated premium impact represents a statewide average. Medicare Supplement plan premiums vary by area. Furthermore, the premium impacts will be higher in some areas than in others. For example, an area that has very little Medicare Advantage presence will not see as much shifting of members into or out of Medicare Advantage.

[25] https://www.insurance.wa.gov/sites/default/files/documents/wa_oic_medicare_supplemental_insurance_legislative_study_11-14-22_0.pdf.

References

Ball G. What Is the Medigap "Birthday Rule" and Which States Have It? 65Medicare.org. August 13, 2023. Available at: https://65medicare.org/what-is-the-medigap-birthday-rule-and-which-states-have-it/. Accessed April 2, 2025.

Boccuti C, Jacobson G, Orgera K, Neuman T. Medigap Enrollment and Consumer Protections Vary Across States. KFF. July 11, 2018. Available at: https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/. Accessed April 12, 2024.

Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare. 2024. Available at: https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf. Accessed March 2, 2025.

Centers for Medicare & Medicaid Services (CMS). Medicare Monthly Enrollment. Centers for Medicare & Medicaid Services Data.CMS.gov. Available at: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment. Accessed June, 2024.

Congressional Budget Office (CBO). Re: Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. 2019. Available at: https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf. Accessed March 16, 2025.

Cubanski J, Neuman T. The Facts on Medicare Spending and Financing Key Facts. Issue Brief. KFF. June 2018. Available at: https://digirepo.nlm.nih.gov/master/borndig/101740287/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing.pdf. Accessed March 20, 2025.

Freed M, Fuglesten Biniek J, Damico A, Cubanski J, Neuman T. Medicare Advantage in 2024: Enrollment Update and Key Trends. KFF. August 8, 2024a. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/. Accessed March 20, 2025.

Freed M, Ochieng N, Cubanski J, Neuman T. Medigap May Be Elusive for Medicare Beneficiaries With Pre-Existing Conditions. KFF. October 18, 2024b. Available at: https://www.kff.org/medicare/issue-brief/medigap-may-be-elusive-for-medicare-beneficiaries-with-pre-existing-conditions/. Accessed March 7, 2025.

Fuglesten Biniek J, Damico A, Cubanski J, Neuman T. Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment. November 1, 2022. Kaiser Family Foundation. Available at: https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/. Accessed April 5, 2025.

GovTrack. H.R. 3 (117th): Elijah E. Cummings Lower Drug Costs Now Act. GovTrack.us. 2021. Available at: https://www.govtrack.us/congress/bills/117/hr3. Accessed April 3, 2025.

Hawai'i State Legislature. SB64 SD1 HD1. Relating to Medicare Supplement Insurance. 2023. Available at: https://www.capitol.hawaii.gov/session/archives/measure_indiv_Archives.aspx?billtype=SB&billnumber=64&year=2023. Accessed April 16, 2025.

Health Management Associates (HMA). Medigap Reform for Medicare Enrollees With ESRD Under Age 65 in California: Prepared for Dialysis Patient Citizens. February 15, 2025. Walnut Creek, CA: Health Management Associates; 2025.

Healthinsurance.org. Medicare in California. March 9, 2023. Available at: https://www.healthinsurance.org/medicare/california/. Accessed April 15, 2025.

Kaiser Family Foundation (KFF). An Overview of Medicare. 2019. Available at: https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/. Accessed April 2, 2025.

Kaiser Family Foundation (KFF). Medicare Advantage Enrollees as a Percent of Total Medicare Population, by Plan Type. State Health Facts. 2023. Available at: https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population-by-plan-type/. Accessed April 1, 2025.

Medicare. Medicare Supplement Insurance: Getting Started. March 2024. Available at: https://www.medicare.gov/publications/11575-Getting-Started-Medicare-Supplement-Insurance.pdf. Accessed April 2, 2025.

Meyers DJ, Belanger E, Joyce N, McHugh J, Rahman M, Mor V. Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries. *JAMA Internal Medicine*. 2019;179(4):524-532. https://doi.org/10.1001/jamainternmed.2018.7639.

Minnesota Legislature. SF 2744. 4th Engrossment. Office of the Revisor of Statues. October 25, 2023. Available at: https://www.revisor.mn.gov/bills/text.php?number=SF2744&session_year=2023&session_number=0&version=latest. Accessed April 1, 2025.

National Association of Insurance Commissioners (NAIC). 2022 Medicare Supplement Loss Ratios. October 25, 2023. Available at: https://content.naic.org/sites/default/files/publication-med-bb-medicare-loss-report.pdf. Accessed April 2, 2024.

Ochieng N, Cubanski J, Neuman T. A Snapshot of Sources of Coverage Among Medicare Beneficiaries. 2024. Kaiser Family Foundation (KFF). Available at: https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/. Accessed March 2, 2025.

Ortner N. Washington State Medicare Supplemental Insurance Study. Milliman. November 11, 2022. Available at: https://www.insurance.wa.gov/sites/default/files/documents/wa_oic_medicare_supplemental_insurance_legislative_study_11-14-22_0.pdf. Accessed April 1, 2025.

Ramsay C, Jacobson G, Findlay S, Cicchiello A. Medicare Advantage: A Policy Primer. The Commonwealth Fund. January 31, 2024.Available at: https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer. Accessed March 1, 2025.

Rhode Island Office of the Health Insurance Commissioner. Updates to Rhode Island's Medicare Supplement Insurance Statute. Bulletin No 2023-01. June 16, 2023. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-06/OHIC%20Bulletin%202023-01_0.pdf. Accessed April 16, 2025.

.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH, Principal Policy Analyst
Karen Shore, **PhD,** Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor working with CHBRP to support analyses and other projects.

Faculty Task Force

Paul Brown, PhD, University of California, Merced
Timothy T. Brown, PhD, University of California, Berkeley
Shana Charles, PhD, MPP, University of California, Los Angeles, and California State University, Fullerton
Janet Coffman, MA, MPP, PhD, *Vice Chair for Medical Effectiveness,* University of California, San Francisco
Todd Gilmer, PhD, University of California, San Diego
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Elizabeth Magnan, MD, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, Davis
Sara McMenamin, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, San Diego
Joy Melnikow, MD, MPH, University of California, Davis
Aimee Moulin, MD, University of California, Davis
Jack Needleman, PhD, University of California, Los Angeles
Mark A. Peterson, PhD, University of California, Los Angeles
Nadereh Pourat, PhD, *Vice Chair for Cost*, University of California, Los Angeles
Dylan Roby, PhD, University of California, Irvine
Marilyn Stebbins, PharmD, University of California, San Francisco
Jonathan Watanabe, PharmD, MS, PhD, University of California, San Francisco

Task Force Contributors

Bethney Bonilla-Herrera, MA, University of California, Davis
Danielle Casteel, MA, University of California, San Diego
Margaret Fix, MPH, University of California, San Francisco
Carlos Gould, PhD, University of California, San Diego
Julia Huerta, BSN, RN, MPH, University of California, Davis
Michelle Keller, PhD, MPH, University of California, Los Angeles, and University of Southern California
Xenia Mendez, MPH, University of California, San Francisco
Thet Nwe Myo Khin, MPH, University of California, San Diego
Jacqueline Miller, University of California, San Francisco
Marykate Miller, MS, University of California, Davis
Katrine Padilla, MPP, University of California, Davis
Kyoko Peterson, MPH, University of California, San Francisco
Amy Quan, MPH, University of California, San Francisco
Dominique Ritley, MPH, University of California, Davis
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego

National Advisory Council

Lauren LeRoy, PhD, Strategic Advisor, L. LeRoy Strategies, *Chair*
Stuart H. Altman, PhD, Professor of National Health Policy, Brandeis University, Waltham, MA
Deborah Chollet, PhD, Senior Fellow, Mathematica Policy Research, Washington, DC
Allen D. Feezor, Former Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, Raleigh, NC
Charles "Chip" Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC
Jeffrey Lerner, PhD, President Emeritus, ECRI Institute Headquarters, Plymouth Meeting, PA; Adjunct Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
Donald E. Metz, Executive Editor, *Health Affairs,* Washington, DC
Dolores Mitchell, (Retired) Executive Director, Group Insurance Commission, Boston, MA
Marilyn Moon, PhD, (Retired) Senior Fellow, American Institutes for Research, Washington, DC
Rachel Nuzman, MPH, Senior Vice President for Federal and State Health Policy, The Commonwealth Fund, New York, NY
Carolyn Pare, (Retired) President and CEO, Minnesota Health Action Group, Bloomington, MN
Osula Evadne Rushing, MPH, Senior Vice President for Strategic Engagement, KFF, Washington, DC
Ruchika Talwar, MD, MMHC, Assistant Professor Department of Urology and Medical Director Episodes of Care, Population Health, Vanderbilt University Medical Center
Alan Weil, JD, MPP, Senior Vice President for Public Policy, AARP, Washington, DC

Acknowledgments

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

Jack Needleman, PhD, of the University of California, Los Angeles, and Dylan Roby, PhD, of the University of California, Irvine, prepared the cost impact analysis. Matt Schoonmaker, FSA, MAAA, of Milliman provided actuarial analysis. Garen Corbett, MS, of CHBRP staff, prepared the Policy Context and Background Sections, and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and a member of the CHBRP Faculty Task Force, Jack Needleman, PhD, and Associate Director Adara Citron, MPH, of CHBRP Staff, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

Garen Corbett, MS Director

Please direct any questions concerning this document to: California Health Benefits Review Program, 1919 Shattuck Avenue, SPH #6102, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

Suggested Citation

California Health Benefits Review Program (CHBRP). (2025). *Abbreviated Analysis of California Senate Bill 242 Medicare Supplement Coverage-Open Enrollment Periods.* Berkeley, CA.