HOUSE BILL REPORT
HB 2317

As Passed House:
February 12, 2002

Title: An act relating to technical changes to Title 48 RCW.

Brief Description: Making technical changes to Title 48 RCW.

Sponsors: By Representatives Cooper and Benson; by request of Insurance Commissioner.

Brief History:
Committee Activity:
Financial Institutions & Insurance: 1/23/02 [DP].
Floor Activity:
Passed House: 2/12/02, 96-0.

Brief Summary of Bill

- Requires insurers to issue medicare supplemental policies to eligible persons who have been terminated from specified medicare supplemental plans or whose plans have been discontinued, and bars price discrimination against such persons due to health status or claims history.
- Limits an insurer's ability to impose exclusions or limitations in medicare supplement policies with respect to preexisting health conditions.
- Makes technical corrections regarding the procedures that must be followed by health insurers in handling complaints from insureds.
- Allows an incorporated domestic insurer to hold its annual meeting at any time and place stated in its bylaws.
- Makes technical corrections to statutory citations in the insurance code.

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS & INSURANCE

Majority Report: Do pass. Signed by 10 members: Representatives Cooper, Chair; McIntire, Vice Chair; Benson, Ranking Minority Member; Barlean, Cairnes, Hatfield, Miloscia, Roach, Santos and Simpson.

Staff: Thamas Osborn (786-7129).

Background:

Medigap Insurance Regulation: Medicare is a federally funded health insurance program administered by the federal Center for Medicaid and Medicare Services (CMS), formerly known as the Health Care Financing Administration. Medicare benefits are available to those who are 65 years of age or over, some disabled persons who are under 65 years of age, and those persons with end-stage kidney disease.

Though Medicare generally pays most of the costs of health care, there are some costs and medical services that are not covered by the program. Accordingly, private insurers offer supplemental insurance policies to cover the costs not subject to coverage under Medicare. These supplemental policies are formally referred to as "Medigap" policies, in reference to their function of filling the various gaps in Medicare coverage. There are 10 standardized Medigap plans offered by private insurers, each of which provides a different set of standard benefits.

The State Insurance Commissioner regulates the private insurance market with respect to the Medigap plans. However, state regulations must meet minimum standards established by the CMS and must be consistent with the pertinent federal law and regulations. The CMS has identified areas of state law regarding medicare supplemental insurance that do not comply with federal requirements. Specifically, state law currently fails to regulate insurers regarding the issuance of Medigap policies to those persons whose supplemental plans have been discontinued or who have been terminated from an existing plan. Also, state law does not address certain issues relating to an insurer's consideration of an insured's preexisting health conditions during the process of replacing one Medigap policy with another.

Complaint Procedures: The insurance code contains two separate sets of procedures by which health insurers are required to handle complaints from insureds. The original procedures, enacted in 1995, apply to both insureds as well as health care providers. The more recent procedures, enacted in 2000, apply only to insureds and consist of comprehensive rules that health insurers must follow regarding grievances received from insureds. The two sets of procedures are redundant and contain inconsistent provisions.

Annual Shareholder Meetings: An incorporated domestic insurer is required to hold its annual shareholder/member meeting in either January, February, March, or April.

Summary of Bill:

Medigap Policies: Subject to certain conditions, an insurer cannot deny a medicare supplement policy to an eligible person who has previously been enrolled in a specified supplemental plan that has been discontinued or terminated. To be eligible, the person must apply for the supplemental coverage from the insurer not later than 63 days after the

date the previous plan was discontinued. In issuing such a policy to an eligible person, an insurer must offer a price that does not discriminate against the insured due to health status or health history, and cannot exclude benefits due to any preexisting condition.

Medigap Coverage/Preexisting Conditions: Under certain circumstances, insurers are prohibited from limiting the coverage of an insured under a medicare supplement replacement policy due an insured's preexisting condition. This regulation applies only if the policy being replaced had been in effect for at least three months.

Complaint Procedures: Health insurers must handle complaints from insureds in accordance with the grievance procedures outlined in the more recent of two applicable statutes. References to insureds are deleted from the earlier complaint procedures statute, thus making that statute applicable only to complaints from health insurance providers.

Annual Meetings: The requirement that incorporated domestic insurers hold annual meetings of shareholders/members in specified months is eliminated. Annual shareholder meetings may be held at any time and place specified in the bylaws.

Citation Corrections: Statutory citations are corrected in laws pertaining to midwives.

Appropriation: None.

Fiscal Note: Not Requested.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: The bill makes several technical corrections to the insurance code. The sections pertaining to supplemental medicare insurance add provisions to state law that are necessary for compliance with the applicable federal law regarding Medicare.

Testimony Against: None.

Testified: (In support) Carrie Tellefson, Office of the Insurance Commissioner.