

HOUSE BILL 2317

State of Washington

57th Legislature

2002 Regular Session

By Representatives Cooper and Benson; by request of Insurance Commissioner

Read first time 01/14/2002. Referred to Committee on Financial Institutions & Insurance.

1 AN ACT Relating to technical changes to Title 48 RCW; amending RCW  
2 48.87.020, 48.87.040, 48.66.130, 48.07.040, and 48.43.055; and adding  
3 a new section to chapter 48.66 RCW.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 48.87.020 and 1993 c 112 s 2 are each amended to read  
6 as follows:

7 Unless the context clearly requires otherwise, the definitions in  
8 this section apply throughout this chapter.

9 (1) "Association" means the joint underwriting association  
10 established under this chapter.

11 (2) "Midwifery and birth center malpractice insurance" means  
12 insurance coverage against the legal liability of the insured and  
13 against loss damage or expense incident to a claim arising out of the  
14 death or injury of a person as a result of negligence or malpractice in  
15 rendering professional service by a licensee.

16 (3) "Licensee" means a person or facility licensed to provide  
17 midwifery services under chapter 18.50, (~~(18.88)~~) 18.79, or 18.46 RCW.

1       **Sec. 2.** RCW 48.87.040 and 1993 c 112 s 4 are each amended to read  
2 as follows:

3       The association shall be comprised of all insurers possessing a  
4 certificate of authority to write and engaged in writing medical  
5 malpractice insurance within this state and general casualty companies.  
6 Every insurer shall be a member of the association and shall remain a  
7 member as a condition of its authority to continue to transact business  
8 in this state. Only licensed midwives under chapter 18.50 RCW,  
9 certified nurse midwives licensed under chapter (~~18.88~~) 18.79 RCW, or  
10 birth centers licensed under chapter 18.46 RCW may participate in the  
11 joint underwriting authority.

12       **Sec. 3.** RCW 48.66.130 and 1995 c 85 s 2 are each amended to read  
13 as follows:

14       (1) On or after January 1, 1996, and notwithstanding any other  
15 provision of Title 48 RCW, a medicare supplement policy or certificate  
16 shall not exclude or limit benefits for losses incurred more than three  
17 months from the effective date of coverage because it involved a  
18 preexisting condition.

19       (2) On or after January 1, 1996, a medicare supplement policy or  
20 certificate shall not define a preexisting condition more restrictively  
21 than as a condition for which medical advice was given or treatment was  
22 recommended by or received from a physician, or other health care  
23 provider acting within the scope of his or her license, within three  
24 months before the effective date of coverage.

25       (3) If a medicare supplement insurance policy or certificate  
26 contains any limitations with respect to preexisting conditions, such  
27 limitations must appear as a separate paragraph of the policy or  
28 certificate and be labeled as "Preexisting Condition Limitations."

29       (4) No exclusion or limitation of preexisting conditions may be  
30 applied to policies or certificates replaced in accordance with the  
31 provisions of RCW 48.66.045 if the policy or certificate replaced had  
32 been in effect for at least three months.

33       NEW SECTION. **Sec. 4.** A new section is added to chapter 48.66 RCW  
34 to read as follows:

35       (1) Under this section, persons eligible for a medicare supplement  
36 policy or certificate are those individuals described in subsection (3)  
37 of this section who, subject to subsection (3)(b)(ii) of this section,

1 apply to enroll under the policy not later than sixty-three days after  
2 the date of the termination of enrollment described in subsection (3)  
3 of this section, and who submit evidence of the date of termination or  
4 disenrollment with the application for a medicare supplement policy.

5 (2) With respect to eligible persons, an issuer may not deny or  
6 condition the issuance or effectiveness of a medicare supplement policy  
7 described in subsection (4) of this section that is offered and is  
8 available for issuance to new enrollees by the issuer, shall not  
9 discriminate in the pricing of such a medicare supplement policy  
10 because of health status, claims experience, receipt of health care, or  
11 medical condition, and shall not impose an exclusion of benefits based  
12 on a preexisting condition under such a medicare supplement policy.

13 (3) "Eligible persons" means an individual that meets the  
14 requirements of (a), (b), (c), (d), (e), or (f) of this subsection, as  
15 follows:

16 (a) The individual is enrolled under an employee welfare benefit  
17 plan that provides health benefits that supplement the benefits under  
18 medicare; and the plan terminates, or the plan ceases to provide all  
19 such supplemental health benefits to the individual;

20 (b)(i) The individual is enrolled with a medicare+choice  
21 organization under a medicare+choice plan under part C of medicare, and  
22 any of the following circumstances apply, or the individual is sixty-  
23 five years of age or older and is enrolled with a program of all  
24 inclusive care for the elderly (PACE) provider under section 1894 of  
25 the social security act, and there are circumstances similar to those  
26 described in this subsection (3)(b) that would permit discontinuance of  
27 the individual's enrollment with the provider if the individual were  
28 enrolled in a medicare+choice plan:

29 (A) The certification of the organization or plan under this  
30 subsection (3)(b) has been terminated, or the organization or plan has  
31 notified the individual of an impending termination of such a  
32 certification;

33 (B) The organization has terminated or otherwise discontinued  
34 providing the plan in the area in which the individual resides, or has  
35 notified the individual of an impending termination or discontinuance  
36 of such a plan;

37 (C) The individual is no longer eligible to elect the plan because  
38 of a change in the individual's place of residence or other change in  
39 circumstances specified by the secretary of the United States

1 department of health and human services, but not including termination  
2 of the individual's enrollment on the basis described in section  
3 1851(g)(3)(B) of the federal social security act (where the individual  
4 has not paid premiums on a timely basis or has engaged in disruptive  
5 behavior as specified in standards under section 1856 of the federal  
6 social security act), or the plan is terminated for all individuals  
7 within a residence area;

8 (D) The individual demonstrates, in accordance with guidelines  
9 established by the secretary of the United States department of health  
10 and human services, that:

11 (I) The organization offering the plan substantially violated a  
12 material provision of the organization's contract under this part in  
13 relation to the individual, including the failure to provide an  
14 enrollee on a timely basis medically necessary care for which benefits  
15 are available under the plan or the failure to provide such covered  
16 care in accordance with applicable quality standards; or

17 (II) The organization, an agent, or other entity acting on the  
18 organization's behalf materially misrepresented the plan's provisions  
19 in marketing the plan to the individual; or

20 (E) The individual meets other exceptional conditions as the  
21 secretary of the United States department of health and human services  
22 may provide.

23 (ii)(A) An individual described in (b)(i) of this subsection may  
24 elect to apply (a) of this subsection by substituting, for the date of  
25 termination of enrollment, the date on which the individual was  
26 notified by the medicare+choice organization of the impending  
27 termination or discontinuance of the medicare+choice plan it offers in  
28 the area in which the individual resides, but only if the individual  
29 disenrolls from the plan as a result of such notification.

30 (B) In the case of an individual making the election under  
31 (b)(ii)(A) of this subsection, the issuer involved shall accept the  
32 application of the individual submitted before the date of termination  
33 of enrollment, but the coverage under subsection (1) of this section  
34 shall only become effective upon termination of coverage under the  
35 medicare+choice plan involved;

36 (c)(i) The individual is enrolled with:

37 (A) An eligible organization under a contract under section 1876  
38 (medicare risk or cost);

1 (B) A similar organization operating under demonstration project  
2 authority, effective for periods before April 1, 1999;

3 (C) An organization under an agreement under section 1833(a)(1)(A)  
4 (health care prepayment plan); or

5 (D) An organization under a medicare select policy; and

6 (ii) The enrollment ceases under the same circumstances that would  
7 permit discontinuance of an individual's election of coverage under  
8 (b)(i) of this subsection;

9 (d) The individual is enrolled under a medicare supplement policy  
10 and the enrollment ceases because:

11 (i)(A) Of the insolvency of the issuer or bankruptcy of the  
12 nonissuer organization; or

13 (B) Of other involuntary termination of coverage or enrollment  
14 under the policy;

15 (ii) The issuer of the policy substantially violated a material  
16 provision of the policy; or

17 (iii) The issuer, an agent, or other entity acting on the issuer's  
18 behalf materially misrepresented the policy's provisions in marketing  
19 the policy to the individual;

20 (e)(i) The individual was enrolled under a medicare supplement  
21 policy and terminates enrollment and subsequently enrolls, for the  
22 first time, with any medicare+choice organization under a  
23 medicare+choice plan under part C of medicare, any eligible  
24 organization under a contract under section 1876 (medicare risk or  
25 cost), any similar organization operating under demonstration project  
26 authority, any PACE program under section 1894 of the social security  
27 act, an organization under an agreement under section 1833(a)(1)(A)  
28 (health care prepayment plan), or a medicare select policy; and

29 (ii) The subsequent enrollment under (e)(i) of this subsection is  
30 terminated by the enrollee during any period within the first twelve  
31 months of such subsequent enrollment (during which the enrollee is  
32 permitted to terminate such subsequent enrollment under section 1851(e)  
33 of the federal social security act); or

34 (f) The individual, upon first becoming eligible for benefits under  
35 part A of medicare at age sixty-five, enrolls in a medicare+choice plan  
36 under part C of medicare, or in a PACE program under section 1894, and  
37 disenrolls from the plan or program by not later than twelve months  
38 after the effective date of enrollment.

1 (4) An eligible person under subsection (3) of this section is  
2 entitled to a medicare supplement policy as follows:

3 (a) A person eligible under subsection (3)(a), (b), (c), and (d) of  
4 this section is entitled to a medicare supplement policy that has a  
5 benefit package classified as plan A through G offered by any issuer;

6 (b) A person eligible under subsection (3)(e) of this section is  
7 entitled to the same medicare supplement policy in which the individual  
8 was most recently previously enrolled, if available from the same  
9 issuer, or, if not so available, a policy described in (a) of this  
10 subsection; and

11 (c) A person eligible under subsection (3)(f) of this section is  
12 entitled to any medicare supplement policy offered by any issuer.

13 (5)(a) At the time of an event described in subsection (3) of this  
14 section, and because of which an individual loses coverage or benefits  
15 due to the termination of a contract, agreement, policy, or plan, the  
16 organization that terminates the contract or agreement, the issuer  
17 terminating the policy, or the administrator of the plan being  
18 terminated, respectively, must notify the individual of his or her  
19 rights under this section, and of the obligations of issuers of  
20 medicare supplement policies under subsection (1) of this section. The  
21 notice must be communicated contemporaneously with the notification of  
22 termination.

23 (b) At the time of an event described in subsection (3) of this  
24 section, and because of which an individual ceases enrollment under a  
25 contract, agreement, policy, or plan, the organization that offers the  
26 contract or agreement, regardless of the basis for the cessation of  
27 enrollment, the issuer offering the policy, or the administrator of the  
28 plan, respectively, must notify the individual of his or her rights  
29 under this section, and of the obligations of issuers of medicare  
30 supplement policies under subsection (1) of this section. The notice  
31 must be communicated within ten working days of the issuer receiving  
32 notification of disenrollment.

33 **Sec. 5.** RCW 48.07.040 and 1985 c 364 s 2 are each amended to read  
34 as follows:

35 Each incorporated domestic insurer shall(~~(, in the month of~~  
36 ~~January, February, March, or April,))~~ hold ((the)) an annual meeting of  
37 its shareholders or members at such time and place as may be stated in  
38 or fixed in accordance with its bylaws for the purpose of receiving

1 reports of its affairs and to elect directors. Each domestic insurance  
2 holding corporation shall hold an annual meeting of its shareholders at  
3 such time and place as may be stated in or fixed in accordance with its  
4 bylaws. Special meetings of the shareholders of an incorporated  
5 domestic insurer or domestic insurance holding corporation shall be  
6 called and held by such persons and in such a manner as stated in the  
7 articles of incorporation or bylaws.

8 **Sec. 6.** RCW 48.43.055 and 1995 c 265 s 20 are each amended to read  
9 as follows:

10 Each health carrier as defined under RCW 48.43.005 shall file with  
11 the commissioner its procedures for review and adjudication of  
12 complaints initiated by ~~((covered persons or))~~ health care providers.  
13 Procedures filed under this section shall provide a fair review for  
14 consideration of complaints. Every health carrier shall provide  
15 reasonable means ~~((whereby))~~ allowing any ~~((person))~~ health care  
16 provider aggrieved by actions of the health carrier ~~((may))~~ to be heard  
17 ~~((in person or by their authorized representative on their))~~ after  
18 submitting a written request for review. If the health carrier fails  
19 to grant or reject ~~((such))~~ a request within thirty days after it is  
20 made, the complaining ~~((person))~~ health care provider may proceed as if  
21 the complaint had been rejected. A complaint that has been rejected by  
22 the health carrier may be submitted to nonbinding mediation. Mediation  
23 shall be conducted ~~((pursuant to))~~ under mediation rules similar to  
24 those of the American arbitration association, the center for public  
25 resources, the judicial arbitration and mediation service, RCW  
26 7.70.100, or any other rules of mediation agreed to by the parties.  
27 This section is solely for resolution of provider complaints.  
28 Complaints by, or on behalf of, a covered person are subject to the  
29 grievance processes in RCW 48.43.530.

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