Z-1237.2

SENATE BILL 6339

State of Washington 57th Legislature 2002 Regular Session

By Senators Keiser, Winsley and Franklin; by request of Insurance Commissioner

Read first time 01/16/2002. Referred to Committee on Health & Long-Term Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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