
HOUSE BILL 1497

State of Washington

59th Legislature

2005 Regular Session

By Representatives Green, Bailey, Cody, Morrell and Kirby; by request of Insurance Commissioner

Read first time 01/26/2005. Referred to Committee on Health Care.

1 AN ACT Relating to the implementation of changes to medicare
2 supplement insurance requirements as mandated by the medicare
3 modernization act of 2003 and other federal requirements; amending RCW
4 48.66.020, 48.66.045, 48.66.055, and 48.66.130; adding a new section to
5 chapter 48.66 RCW; and creating a new section.

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

7 NEW SECTION. **Sec. 1.** This act is intended to satisfy the
8 directive from the centers for medicare and medicaid services requiring
9 states to implement changes to their medicare supplement insurance
10 requirements to comply with the standards prescribed by the medicare
11 modernization act that are consistent with amendments to the national
12 association of insurance commissioners medicare supplement insurance
13 minimum standards model act along with other corrections to be
14 compliant with federal requirements.

15 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.66 RCW
16 to read as follows:

17 (1) An issuer may not deny or condition the issuance or
18 effectiveness of any medicare supplement policy or certificate

1 available for sale in this state, or discriminate in the pricing of a
2 policy or certificate, because of the health status, claims experience,
3 receipt of health care, or medical condition of an applicant in the
4 case of an application for a policy or certificate that is submitted
5 prior to or during the six-month period beginning with the first day of
6 the first month in which an individual is both sixty-five years of age
7 or older and is enrolled for benefits under medicare part B. Each
8 medicare supplement policy and certificate currently available from an
9 insurer must be made available to all applicants who qualify under this
10 subsection without regard to age.

11 (2) If an applicant qualifies under this section and submits an
12 application during the time period referenced in subsection (1) of this
13 section and, as of the date of application, has had a continuous period
14 of creditable coverage of at least three months, the issuer may not
15 exclude benefits based on a preexisting condition.

16 (3) If an applicant qualified under this section submits an
17 application during the time period referenced in subsection (1) of this
18 section and, as of the date of application, has had a continuous period
19 of creditable coverage that is less than three months, the issuer must
20 reduce the period of any preexisting condition exclusion by the
21 aggregate of the period of creditable coverage applicable to the
22 applicant as of the enrollment date.

23 **Sec. 3.** RCW 48.66.020 and 1996 c 269 s 1 are each amended to read
24 as follows:

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

27 (1) "Medicare supplemental insurance" or "medicare supplement
28 insurance policy" refers to a group or individual policy of disability
29 insurance or a subscriber contract of a health care service contractor,
30 a health maintenance organization, or a fraternal benefit society,
31 which relates its benefits to medicare, or which is advertised,
32 marketed, or designed primarily as a supplement to reimbursements under
33 medicare for the hospital, medical, or surgical expenses of persons
34 eligible for medicare. Such term does not include:

35 (a) A policy or contract of one or more employers or labor
36 organizations, or of the trustees of a fund established by one or more

1 employers or labor organizations, or combination thereof, for employees
2 or former employees, or combination thereof, or for members or former
3 members, or combination thereof, of the labor organizations; or

4 (b) A policy issued pursuant to a contract under section 1876 of
5 the federal social security act (42 U.S.C. Sec. 1395 et seq.), or an
6 issued policy under a demonstration specified in 42 U.S.C. Sec.
7 1395(g)(1); or

8 ~~((Insurance policies or health care benefit plans, including~~
9 ~~group conversion policies, provided to medicare eligible persons, that~~
10 ~~are not marketed or held to be medicare supplement policies or benefit~~
11 ~~plans)) Medicare advantage plans established under medicare part C; or~~

12 (d) Outpatient prescription drug plans established under medicare
13 part D; or

14 (e) Any health care prepayment plan that provides benefits pursuant
15 to an agreement under section 1833(a)(1)(A) of the federal social
16 security act.

17 (2) "Medicare" means the "Health Insurance for the Aged Act," Title
18 XVIII of the Social Security Amendments of 1965, as then constituted or
19 later amended.

20 (3) "Medicare advantage plan" means a plan of coverage for health
21 benefits under medicare part C as defined in 42 U.S.C. Sec.
22 1395w-28(b), and includes:

23 (a) Coordinated care plans which provide health care services,
24 including but not limited to health maintenance organization plans
25 (with or without a point-of-service option), plans offered by
26 provider-sponsored organizations, and preferred provider organization
27 plans;

28 (b) Medical savings account plans coupled with a contribution into
29 a medicare advantage plan medical savings account; and

30 (c) Medicare advantage private fee-for-service plans.

31 (4) "Medicare eligible expenses" means health care expenses of the
32 kinds covered by medicare parts A and B, to the extent recognized as
33 reasonable and medically necessary by medicare.

34 ~~((4))~~ (5) "Applicant" means:

35 (a) In the case of an individual medicare supplement insurance
36 policy or subscriber contract, the person who seeks to contract for
37 insurance benefits; and

1 (b) In the case of a group medicare supplement insurance policy or
2 subscriber contract, the proposed certificate holder.

3 ~~((+5))~~ (6) "Certificate" means any certificate delivered or issued
4 for delivery in this state under a group medicare supplement insurance
5 policy.

6 ~~((+6))~~ (7) "Loss ratio" means the incurred claims as a percentage
7 of the earned premium computed under rules adopted by the insurance
8 commissioner.

9 ~~((+7))~~ (8) "Preexisting condition" means a covered person's
10 medical condition that caused that person to have received medical
11 advice or treatment during a specified time period immediately prior to
12 the effective date of coverage.

13 ~~((+8))~~ (9) "Disclosure form" means the form designated by the
14 insurance commissioner which discloses medicare benefits, the
15 supplemental benefits offered by the insurer, and the remaining amount
16 for which the insured will be responsible.

17 ~~((+9))~~ (10) "Issuer" includes insurance companies, health care
18 service contractors, health maintenance organizations, fraternal
19 benefit societies, and any other entity delivering or issuing for
20 delivery medicare supplement policies or certificates to a resident of
21 this state.

22 (11) "Bankruptcy" means when a medicare advantage organization that
23 is not an issuer has filed, or has had filed against it, a petition for
24 declaration of bankruptcy and has ceased doing business in the state.

25 (12) "Continuous period of creditable coverage" means the period
26 during which an individual was covered by creditable coverage, if
27 during the period of the coverage the individual had no breaks in
28 coverage greater than sixty-three days.

29 (13)(a) "Creditable coverage" means, with respect to an individual,
30 coverage of the individual provided under any of the following:

31 (i) A group health plan;

32 (ii) Health insurance coverage;

33 (iii) Part A or part B of Title XVIII of the social security act
34 (medicare);

35 (iv) Title XIX of the social security act (medicaid), other than
36 coverage consisting solely of benefits under section 1928;

37 (v) Chapter 55 of Title 10 U.S.C. (CHAMPUS);

1 (vi) A medical care program of the Indian health service or of a
2 tribal organization;

3 (vii) A state health benefits risk pool;

4 (viii) A health plan offered under chapter 89 of Title 5 U.S.C.
5 (federal employees health benefits program);

6 (ix) A public health plan as defined in federal regulation; and

7 (x) A health benefit plan under section 5(e) of the peace corps act
8 (22 U.S.C. Sec. 2504(e)).

9 (b) "Creditable coverage" does not include one or more, or any
10 combination, of the following:

11 (i) Coverage only for accident or disability income insurance, or
12 any combination thereof;

13 (ii) Coverage issued as a supplement to liability insurance;

14 (iii) Liability insurance, including general liability insurance
15 and automobile liability insurance;

16 (iv) Worker's compensation or similar insurance;

17 (v) Automobile medical payment insurance;

18 (vi) Credit-only insurance;

19 (vii) Coverage for on-site medical clinics; and

20 (viii) Other similar insurance coverage, specified in federal
21 regulations, under which benefits for medical care are secondary or
22 incidental to other insurance benefits.

23 (c) "Creditable coverage" does not include the following benefits
24 if they are provided under a separate policy, certificate, or contract
25 of insurance or are otherwise not an integral part of the plan:

26 (i) Limited scope dental or vision benefits;

27 (ii) Benefits for long-term care, nursing home care, home health
28 care, community-based care, or any combination thereof; and

29 (iii) Other similar, limited benefits as are specified in federal
30 regulations.

31 (d) "Creditable coverage" does not include the following benefits
32 if offered as independent, noncoordinated benefits:

33 (i) Coverage only for a specified disease or illness; and

34 (ii) Hospital indemnity or other fixed indemnity insurance.

35 (e) "Creditable coverage" does not include the following if it is
36 offered as a separate policy, certificate, or contract of insurance:

37 (i) Medicare supplemental health insurance as defined under section
38 1882(g)(1) of the social security act;

1 (ii) Coverage supplemental to the coverage provided under chapter
2 55 of Title 10 U.S.C.; and

3 (iii) Similar supplemental coverage provided to coverage under a
4 group health plan.

5 (14) "Employee welfare benefit plan" means a plan, fund, or program
6 of employee benefits as defined in 29 U.S.C. Sec. 1002 (employee
7 retirement income security act).

8 (15) "Insolvency" means when an issuer, licensed to transact the
9 business of insurance in this state, has had a final order of
10 liquidation entered against it with a finding of insolvency by a court
11 of competent jurisdiction in the issuer's state of domicile.

12 **Sec. 4.** RCW 48.66.045 and 2004 c 83 s 1 are each amended to read
13 as follows:

14 Every issuer of a medicare supplement insurance policy or
15 certificate providing coverage to a resident of this state issued on or
16 after January 1, 1996, shall:

17 (1) Unless otherwise provided for in RCW 48.66.055, issue coverage
18 under its standardized benefit plans B, C, D, E, F, (~~and~~) G, K, and
19 L without evidence of insurability to any resident of this state who is
20 eligible for both medicare hospital and physician services by reason of
21 age or by reason of disability or end-stage renal disease, if the
22 medicare supplement policy replaces another medicare supplement
23 standardized benefit plan policy or certificate B, C, D, E, F, (~~or~~)
24 G, K, or L, or other more comprehensive coverage than the replacing
25 policy;

26 (2) Unless otherwise provided for in RCW 48.66.055, issue coverage
27 under its standardized plans A, H, I, and J without evidence of
28 insurability to any resident of this state who is eligible for both
29 medicare hospital and physician services by reason of age or by reason
30 of disability or end-stage renal disease, if the medicare supplement
31 policy replaces another medicare supplement policy or certificate which
32 is the same standardized plan as the replaced policy. After December
33 31, 2005, plans H, I, and J may be replaced only by the same plan if
34 that plan has been modified to remove outpatient prescription drug
35 coverage; and

36 (3) Set rates only on a community-rated basis. Premiums shall be
37 equal for all policyholders and certificate holders under a

1 standardized medicare supplement benefit plan form, except that an
2 issuer may vary premiums based on spousal discounts, frequency of
3 payment, and method of payment including automatic deposit of premiums
4 and may develop no more than two rating pools that distinguish between
5 an insured's eligibility for medicare by reason of:

- 6 (a) Age; or
- 7 (b) Disability or end-stage renal disease.

8 **Sec. 5.** RCW 48.66.055 and 2002 c 300 s 4 are each amended to read
9 as follows:

10 (1) Under this section, persons eligible for a medicare supplement
11 policy or certificate are those individuals described in subsection (3)
12 of this section who, subject to subsection (3)(b)(ii) of this section,
13 apply to enroll under the policy not later than sixty-three days after
14 the date of the termination of enrollment described in subsection (3)
15 of this section, and who submit evidence of the date of termination or
16 disenrollment, or medicare part D enrollment, with the application for
17 a medicare supplement policy.

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

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

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

33 (b)(i) The individual is enrolled with a (~~medicare+choice~~)
34 medicare advantage organization under a (~~medicare+choice~~) medicare
35 advantage plan under part C of medicare, and any of the following
36 circumstances apply, or the individual is sixty-five years of age or
37 older and is enrolled with a program of all inclusive care for the

1 elderly (PACE) provider under section 1894 of the social security act,
2 and there are circumstances similar to those described in this
3 subsection (3)(b) that would permit discontinuance of the individual's
4 enrollment with the provider if the individual were enrolled in a
5 (~~medicare+choice~~) medicare advantage plan:

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

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

14 (C) The individual is no longer eligible to elect the plan because
15 of a change in the individual's place of residence or other change in
16 circumstances specified by the secretary of the United States
17 department of health and human services, but not including termination
18 of the individual's enrollment on the basis described in section
19 1851(g)(3)(B) of the federal social security act (where the individual
20 has not paid premiums on a timely basis or has engaged in disruptive
21 behavior as specified in standards under section 1856 of the federal
22 social security act), or the plan is terminated for all individuals
23 within a residence area;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (e)(i) The individual was enrolled under a medicare supplement
38 policy and terminates enrollment and subsequently enrolls, for the

1 first time, with any (~~(medicare+choice)~~) medicare advantage
2 organization under a (~~(medicare+choice)~~) medicare advantage plan under
3 part C of medicare, any eligible organization under a contract under
4 section 1876 (medicare risk or cost), any similar organization
5 operating under demonstration project authority, any PACE program under
6 section 1894 of the social security act(~~(, an organization under an~~
7 ~~agreement under section 1833(a)(1)(A) (health care prepayment plan),)~~)
8 or a medicare select policy; and

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

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

19 (g) The individual enrolls in a medicare part D plan during the
20 initial enrollment period and, at the time of enrollment in part D, was
21 enrolled under a medicare supplement policy that covers outpatient
22 prescription drugs, and the individual terminates enrollment in the
23 medicare supplement policy and submits evidence of enrollment in
24 medicare part D along with the application for a policy described in
25 subsection (4)(d) of this section.

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

28 (a) A person eligible under subsection (3)(a), (b), (c), and (d) of
29 this section is entitled to a medicare supplement policy that has a
30 benefit package classified as plan A through (~~(G))~~ F (including F with
31 a high deductible), K, or L, offered by any issuer;

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

37 (ii) After December 31, 2005, if the individual was most recently

1 enrolled in a medicare supplement policy with an outpatient
2 prescription drug benefit, a medicare supplement policy described in
3 this subsection (4)(b)(ii) is:

4 (A) The policy available from the same issuer but modified to
5 remove outpatient prescription drug coverage; or

6 (B) At the election of the policyholder, an A, B, C, F (including
7 F with a high deductible), K, or L policy that is offered by any
8 issuer;

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

11 (d) A person eligible under subsection (3)(g) of this section is
12 entitled to a medicare supplement policy that has a benefit package
13 classified as plan A, B, C, F (including F with a high deductible), K,
14 or L and that is offered and is available for issuance to new enrollees
15 by the same issuer that issued the individual's medicare supplement
16 policy with outpatient prescription drug coverage.

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

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

37 (6) Guaranteed issue time periods:

1 (a) In the case of an individual described in subsection (3)(a) of
2 this section, the guaranteed issue period begins on the later of: (i)
3 The date the individual receives a notice of termination or cessation
4 of all supplemental health benefits (or, if a notice is not received,
5 notice that a claim has been denied because of a termination or
6 cessation), or (ii) the date that the applicable coverage terminates or
7 ceases, and ends sixty-three days thereafter;

8 (b) In the case of an individual described in subsection (3)(b),
9 (c), (e), or (f) of this section whose enrollment is terminated
10 involuntarily, the guaranteed issue period begins on the date that the
11 individual receives a notice of termination and ends sixty-three days
12 after the date the applicable coverage is terminated;

13 (c) In the case of an individual described in subsection (3)(d)(i)
14 of this section, the guaranteed issue period begins on the earlier of:
15 (i) The date that the individual receives a notice of termination, a
16 notice of the issuer's bankruptcy or insolvency, or other such similar
17 notice if any, and (ii) the date that the applicable coverage is
18 terminated, and ends on the date that is sixty-three days after the
19 date the coverage is terminated;

20 (d) In the case of an individual described in subsection (3)(b),
21 (d)(ii) and (iii), (e), or (f) of this section, who disenrolls
22 voluntarily, the guaranteed issue period begins on the date that is
23 sixty days before the effective date of the disenrollment and ends on
24 the date that is sixty-three days after the effective date;

25 (e) In the case of an individual described in subsection (3)(g) of
26 this section, the guaranteed issue period begins on the date the
27 individual receives notice pursuant to section 1882(v)(2)(B) of the
28 federal social security act from the medicare supplement issuer during
29 the sixty-day period immediately preceding the initial part D
30 enrollment period and ends on the date that is sixty-three days after
31 the effective date of the individual's coverage under medicare part D;
32 and

33 (f) In the case of an individual described in subsection (3) of
34 this section but not described in the preceding provisions of this
35 subsection, the guaranteed issue period begins on the effective date of
36 disenrollment and ends on the date that is sixty-three days after the
37 effective date.

1 (7) In the case of an individual described in subsection (3)(e) of
2 this section whose enrollment with an organization or provider
3 described in subsection (3)(e)(i) of this section is involuntarily
4 terminated within the first twelve months of enrollment, and who,
5 without an intervening enrollment, enrolls with another organization or
6 provider, the subsequent enrollment is an initial enrollment as
7 described in subsection (3)(e) of this section.

8 (8) In the case of an individual described in subsection (3)(f) of
9 this section whose enrollment with a plan or in a program described in
10 subsection (3)(f) of this section is involuntarily terminated within
11 the first twelve months of enrollment, and who, without an intervening
12 enrollment, enrolls in another plan or program, the subsequent
13 enrollment is an initial enrollment as described in subsection (3)(f)
14 of this section.

15 (9) For purposes of subsection (3)(e) and (f) of this section, an
16 enrollment of an individual with an organization or provider described
17 in subsection (3)(e)(i) of this section, or with a plan or in a program
18 described in subsection (3)(f) of this section is not an initial
19 enrollment under this subsection after the two-year period beginning on
20 the date on which the individual first enrolled with such an
21 organization, provider, plan, or program.

22 **Sec. 6.** RCW 48.66.130 and 2002 c 300 s 3 are each amended to read
23 as follows:

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

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

35 (3) If a medicare supplement insurance policy or certificate
36 contains any limitations with respect to preexisting conditions, such

1 limitations must appear as a separate paragraph of the policy or
2 certificate and be labeled as "Preexisting Condition Limitations."

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

7 (5) If a medicare supplement policy or certificate replaces another
8 medicare supplement policy or certificate, the replacing issuer shall
9 waive any time periods applicable to preexisting conditions, waiting
10 periods, elimination periods, and probationary periods in the new
11 medicare supplement policy or certificate for similar benefits to the
12 extent such time was spent under the original policy.

13 (6) If a medicare supplement policy or certificate replaces another
14 medicare supplement policy or certificate which has been in effect for
15 at least three months, the replacing policy shall not provide any time
16 period applicable to preexisting conditions, waiting periods,
17 elimination periods, and probationary periods for benefits similar to
18 those contained in the original policy or certificate.

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