
HOUSE BILL 1484

State of Washington

66th Legislature

2019 Regular Session

By Representatives Thai, Cody, Slatter, and Jinkins; by request of Insurance Commissioner

Read first time 01/23/19. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to medicare supplemental insurance policies; and
2 amending RCW 48.66.045 and 48.66.055.

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

4 **Sec. 1.** RCW 48.66.045 and 2010 c 27 s 3 are each amended to read
5 as follows:

6 (1) Every issuer of a medicare supplement insurance policy or
7 certificate providing coverage to a resident of this state issued on
8 or after January 1, 1996, and before June 1, 2010, must:

9 (a) Unless otherwise provided for in RCW 48.66.055, issue
10 coverage under its standardized benefit plans B, C, D, E, F, G, K,
11 and L without evidence of insurability to any resident of this state
12 who is eligible for both medicare hospital and physician services by
13 reason of age or by reason of disability or end-stage renal disease,
14 if the medicare supplement policy replaces another medicare
15 supplement standardized benefit plan policy or certificate B, C, D,
16 E, F, G, K, or L, or other more comprehensive coverage than the
17 replacing policy; and

18 (b) Unless otherwise provided for in RCW 48.66.055, issue
19 coverage under its standardized plans A, H, I, and J without evidence
20 of insurability to any resident of this state who is eligible for
21 both medicare hospital and physician services by reason of age or by

1 reason of disability or end-stage renal disease, if the medicare
2 supplement policy replaces another medicare supplement policy or
3 certificate which is the same standardized plan as the replaced
4 policy. After December 31, 2005, plans H, I, and J may be replaced
5 only by the same plan if that plan has been modified to remove
6 outpatient prescription drug coverage.

7 (2)(a) Unless otherwise provided for in RCW 48.66.055, every
8 issuer of a medicare supplement insurance policy or certificate
9 providing coverage to a resident of this state issued on or after
10 June 1, 2010, must issue coverage under its standardized plans B, C,
11 D, F, F with high deductible, G, G with high deductible, K, L, M, or
12 N without evidence of insurability to any resident of this state who
13 is eligible for both medicare hospital and physician services prior
14 to January 1, 2020, by reason of age or by reason of disability or
15 end-stage renal disease, if the medicare supplement policy or
16 certificate replaces another medicare supplement policy or
17 certificate or other more comprehensive coverage; (~~and~~)

18 (b) Unless otherwise provided in RCW 48.66.055, every issuer of a
19 medicare supplement insurance policy or certificate providing
20 coverage to a resident of this state issued on or after January 1,
21 2020, must issue coverage under its standardized plans B, D, G, G
22 with high deductible, K, L, M, or N without evidence of insurability
23 to any resident of this state who is eligible for both medicare
24 hospital and physician services on or after January 1, 2020, by
25 reason of age, disability, or end-stage renal disease, if the
26 medicare supplement policy or certificate replaces another medicare
27 supplement policy or certificate or other more comprehensive
28 coverage; and

29 (c) Unless otherwise provided for in RCW 48.66.055, issue
30 coverage under its standardized plan A without evidence of
31 insurability to any resident of this state who is eligible for both
32 medicare hospital and physician services by reason of age or by
33 reason of disability or end-stage renal disease, if the medicare
34 supplement policy or certificate replaces another standardized plan A
35 medicare supplement policy or certificate.

36 (3) Every issuer of a medicare supplement insurance policy or
37 certificate providing coverage to a resident of this state issued on
38 or after January 1, 1996, must set rates only on a community-rated
39 basis. Premiums must be equal for all policyholders and certificate
40 holders under a standardized medicare supplement benefit plan form,

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

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

8 **Sec. 2.** RCW 48.66.055 and 2008 c 217 s 64 are each amended to
9 read as follows:

10 (1) Under this section, persons eligible for a medicare
11 supplement policy or certificate are those individuals described in
12 subsection (3) of this section who, subject to subsection (3)(b)(ii)
13 of this section, apply to enroll under the policy not later than
14 sixty-three days after the date of the termination of enrollment
15 described in subsection (3) of this section, and who submit evidence
16 of the date of termination or disenrollment, or medicare part D
17 enrollment, with the application for 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
20 policy described in subsection (4) of this section that is offered
21 and is available for issuance to new enrollees by the issuer, shall
22 not discriminate in the pricing of such a medicare supplement policy
23 because of health status, claims experience, receipt of health care,
24 or medical condition, and shall not impose an exclusion of benefits
25 based on a preexisting condition under such a medicare supplement
26 policy.

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

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

34 (b)(i) The individual is enrolled with a medicare advantage
35 organization under a medicare advantage plan under part C of
36 medicare, and any of the following circumstances apply, or the
37 individual is sixty-five years of age or older and is enrolled with a
38 program of all inclusive care for the elderly (PACE) provider under
39 section 1894 of the social security act, and there are circumstances

1 similar to those described in this subsection (3)(b) that would
2 permit discontinuance of the individual's enrollment with the
3 provider if the individual were enrolled in a medicare advantage
4 plan:

5 (A) The certification of the organization or plan has been
6 terminated;

7 (B) The organization has terminated or otherwise discontinued
8 providing the plan in the area in which the individual resides;

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

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

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

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

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

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

1 (B) In the case of an individual making the election under
2 (b)(ii)(A) of this subsection, the issuer involved shall accept the
3 application of the individual submitted before the date of
4 termination of enrollment, but the coverage under subsection (1) of
5 this section is only effective upon termination of coverage under the
6 medicare advantage plan involved;

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

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

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

12 (C) An organization under an agreement under section
13 1833(a)(1)(A) (health care prepayment plan); or

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

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

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

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

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

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

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

29 (e)(i) The individual was enrolled under a medicare supplement
30 policy and terminates enrollment and subsequently enrolls, for the
31 first time, with any medicare advantage organization under a medicare
32 advantage plan under part C of medicare, any eligible organization
33 under a contract under section 1876 (medicare risk or cost), any
34 similar organization operating under demonstration project authority,
35 any PACE program under section 1894 of the social security act or a
36 medicare select policy; and

37 (ii) The subsequent enrollment under (e)(i) of this subsection is
38 terminated by the enrollee during any period within the first twelve
39 months of such subsequent enrollment (during which the enrollee is

1 permitted to terminate such subsequent enrollment under section
2 1851(e) of the federal social security act);

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

8 (g) The individual enrolls in a medicare part D plan during the
9 initial enrollment period and, at the time of enrollment in part D,
10 was enrolled under a medicare supplement policy that covers
11 outpatient prescription drugs, and the individual terminates
12 enrollment in the medicare supplement policy and submits evidence of
13 enrollment in medicare part D along with the application for a policy
14 described in subsection (4) ~~((d))~~ (a)(iv) of this section.

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

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

21 ~~((b)(i))~~ (ii)(A) Subject to ~~((b)(ii))~~ (a)(ii)(B) of this
22 subsection, a person eligible under subsection (3)(e) of this section
23 is entitled to the same medicare supplement policy in which the
24 individual was most recently previously enrolled, if available from
25 the same issuer, or, if not so available, a policy described in (a)
26 (i) of this subsection;

27 ~~((ii))~~ (B) After December 31, 2005, if the individual was most
28 recently enrolled in a medicare supplement policy with an outpatient
29 prescription drug benefit, a medicare supplement policy described in
30 this subsection ~~((b)(ii))~~ (a)(ii)(B) is:

31 ~~((A))~~ (I) The policy available from the same issuer but
32 modified to remove outpatient prescription drug coverage; or

33 ~~((B))~~ (II) At the election of the policyholder, an A, B, C, F
34 (including F with a high deductible), K, or L policy that is offered
35 by any issuer;

36 ~~((e))~~ (iii) A person eligible under subsection (3)(f) of this
37 section is entitled to any medicare supplement policy offered by any
38 issuer; and

39 ~~((d))~~ (iv) A person eligible under subsection (3)(g) of this
40 section is entitled to a medicare supplement policy that has a

1 benefit package classified as plan A, B, C, F (including F with a
2 high deductible), K, or L and that is offered and is available for
3 issuance to new enrollees by the same issuer that issued the
4 individual's medicare supplement policy with outpatient prescription
5 drug coverage.

6 (b) For purposes of this subsection (4), in the case of any
7 individual newly eligible for medicare on or after January 1, 2020,
8 any reference to a medicare supplement policy C or F, including F
9 with high deductible, is deemed to be a reference to a medicare
10 supplement policy D or G, including G with high deductible,
11 respectively, that meets the requirements of this subsection.

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

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

32 (6) Guaranteed issue time periods:

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

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

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

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

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

26 (f) In the case of an individual described in subsection (3) of
27 this section but not described in the preceding provisions of this
28 subsection, the guaranteed issue period begins on the effective date
29 of disenrollment and ends on the date that is sixty-three days after
30 the effective date.

31 (7) In the case of an individual described in subsection (3)(e)
32 of this section whose enrollment with an organization or provider
33 described in subsection (3)(e)(i) of this section is involuntarily
34 terminated within the first twelve months of enrollment, and who,
35 without an intervening enrollment, enrolls with another organization
36 or provider, the subsequent enrollment is an initial enrollment as
37 described in subsection (3)(e) of this section.

38 (8) In the case of an individual described in subsection (3)(f)
39 of this section whose enrollment with a plan or in a program
40 described in subsection (3)(f) of this section is involuntarily

1 terminated within the first twelve months of enrollment, and who,
2 without an intervening enrollment, enrolls in another plan or
3 program, the subsequent enrollment is an initial enrollment as
4 described in subsection (3)(f) of this section.

5 (9) For purposes of subsection (3)(e) and (f) of this section, an
6 enrollment of an individual with an organization or provider
7 described in subsection (3)(e)(i) of this section, or with a plan or
8 in a program described in subsection (3)(f) of this section is not an
9 initial enrollment under this subsection after the two-year period
10 beginning on the date on which the individual first enrolled with
11 such an organization, provider, plan, or program.

--- END ---