RCW 48.66.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

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

(a) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

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

(c) Medicare advantage plans established under medicare part C; or

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

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

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

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

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

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

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

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

(5) "Applicant" means:

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

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

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

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

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

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

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

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

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

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

(i) A group health plan;

(ii) Health insurance coverage;

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

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

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

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

(vii) A state health benefits risk pool;

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

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

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

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

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

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

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

(iv) Worker's compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

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

(i) Limited scope dental or vision benefits;

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

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

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

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

(15) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile. [2005 c 41 s 3; 1996 c 269 s 1; 1995 c 85 s 1; 1992 c 138 s 1; 1981 c 153 s 2.]

Intent—2005 c 41: See note following RCW 48.66.025.

Effective date—1996 c 269: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [March 29, 1996]." [1996 c 269 s 2.]