Z-0109.1

SENATE BILL 5032

State of Washington 66th Legislature 2019 Regular Session

By Senators Cleveland, Keiser, and O'Ban; by request of Insurance Commissioner

Prefiled 12/21/18. Read first time 01/14/19. Referred to Committee on Health & Long Term Care.

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

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

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

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

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

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

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

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

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

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

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

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

(a) Age; or

(b) Disability or end-stage renal disease.

Sec. 2. RCW 48.66.055 and 2008 c 217 s 64 are each amended 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, or medicare part D enrollment, 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 advantage organization under a medicare advantage 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 advantage plan:

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

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

(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 insurance producer, 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 advantage organization of the impending termination or discontinuance of the medicare advantage 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 is only effective upon termination of coverage under the medicare advantage 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 insurance producer, 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 advantage organization under a medicare advantage 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 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);

(f) The individual, upon first becoming eligible for benefits under part A of medicare at age sixty-five, enrolls in a medicare advantage 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; or

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

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

((~~(a)~~)) (i) 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 F (including F with a high deductible), K, or L, offered by any issuer;

((~~(b)(i)~~)) (ii)(A) Subject to ((~~(b)(ii)~~)) (a)(ii)(B) of this subsection, 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)(i) of this subsection;

((~~(ii)~~)) (B) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subsection (4)((~~(b)(ii)~~)) (a)(ii)(B) is:

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

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

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

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

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

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

(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.

(6) Guaranteed issue time periods:

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

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

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

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

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

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

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

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

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

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

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