EXPEDITED RULE MAKING

CR-105 (October 2017)
(Implements RCW 34.05.353)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 31, 2019
TIME: 11:34 AM

WSR 19-12-061

Agency: Office of the Insurance Commissioner

Title of rule and other identifying information: (describe subject) Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changes to Medicare Supplemental Policies and Certificates.

Insurance Commissioner Matter R 2019-01

Purpose of the proposal and its anticipated effects, including any changes in existing rules: Amend existing rules to conform to changes in Federal Law to Medicare Supplemental policies by the Medicare Access and CHIP Reauthorization Act of 2015 and Chapter 38, Laws of 2019.

Reasons supporting proposal: The Medicare Access and CHIP Reauthorization Act of 2015 and Chapter 38, Laws of 2019 (SB 5032) made changes to the requirements for Medicare Supplemental plans. This proposed rule is needed to amend existing rules to comply with these changes.

Statutory authority for adoption: RCW 48.02.060, RCW 48.66.041, and RCW 48.66.165.

Statute being implemented: Chapter 38, Laws of 2019

Is rule necessary because of a:

Federal Law?	☒ Yes	☐ No
Federal Court Decision?	☐ Yes	☐ No
State Court Decision?	☐ Yes	☐ No

If yes, CITATION: Medicare Access and CHIP Reauthorization Act of 2015

Name of proponent: (person or organization) Mike Kreidler, Insurance Commissioner

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Jim Tompkins	PO Box 40260, Olympia, WA 98504-0260	(360) 725-7036
Implementation:	Molly Nollette	PO Box 40255, Olympia, WA 98504-0260	(360) 725-7117
Enforcement:	Molly Nollette	PO Box 40255, Olympia, WA 98504-0260	(360) 725-7117

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Expedited Adoption - Which of the following criteria was used by the agency to file this notice:

☐ Relates only to internal governmental operations that are not subject to violation by a person;

☒ Adopts or incorporates by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule;

☐ Corrects typographical errors, make address or name changes, or clarify language of a rule without changing its effect;

☒ Content is explicitly and specifically dictated by statute;

☐ Have been the subject of negotiated rule making, pilot rule making, or some other process that involved substantial participation by interested parties before the development of the proposed rule; or

☐ Is being amended after a review under RCW 34.05.328.

Expedited Repeal - Which of the following criteria was used by the agency to file notice:

☐ The statute on which the rule is based has been repealed and has not been replaced by another statute providing statutory authority for the rule;

☐ The statute on which the rule is based has been declared unconstitutional by a court with jurisdiction, there is a final judgment, and no statute has been enacted to replace the unconstitutional statute;

☐ The rule is no longer necessary because of changed circumstances; or

☐ Other rules of the agency or of another agency govern the same activity as the rule, making the rule redundant.

Explanation of the reason the agency believes the expedited rule-making process is appropriate pursuant to RCW 34.05.353(4): The Medicare Access and CHIP Reauthorization Act of 2015 and Chapter 38, Laws of 2019 (SB 5032) made changes to the requirements for Medicare Supplemental plans. This proposed rule will amend existing rules to comply with these changes federal law and statutory changes.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO

Name: Jim Tompkins

Agency: Office of the Insurance Commissioner

Address: PO Box 40260, Olympia, WA 98504-0260

Phone: (360) 725-7036

Fax: (360) 586-3109

Email: rulescoordinator@oic.wa.gov

Other:

AND RECEIVED BY (date) August 6, 2019

Date: 05/31/2019

Name: Mike Kreidler

Title: Insurance Commissioner

Signature:

AMENDATORY SECTION (Amending WSR 11-17-077, filed 8/16/11, effective 9/16/11)

WAC 284-66-064 Benefit standards for policies or certificates issued or delivered on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to medicare supplement policies or certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-060 and 284-66-063.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) 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. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) No medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured other than the nonpayment of premium.

(d) Each medicare supplement policy shall be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (d)(v) of this subsection, the issuer shall offer certificate holders an individual medicare supplement policy which, at the option of the certificate holder:

(A) Provides for continuation of the benefits contained in the group policy; or

(B) Provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(A) Offer the certificate holder the conversion opportunity described in (d)(iii) of this subsection; or

(B) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issue of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination.

(vi) Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

(vii)(A) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate are suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance.

(B) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(C) Each medicare supplement policy must provide that benefits and premiums under the policy must be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(viii) Reinstitution of coverages as described in this section:

(A) Must not provide for any waiting period with respect to treatment of preexisting conditions;

(B) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(C) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) Every issuer of medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance plans in addition to the basic core package, but not in lieu of it.

(a) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

(b) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible.

(f) Coverage of cost sharing for all Part A medicare eligible hospice care and respite care expenses.

(3) The following additional benefits must be included in medicare supplement benefit plans B, C, D, F, F with high deductible, G, M, and N as provided by WAC 284-66-066:

(a) Coverage for one hundred percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(b) Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(c) Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A.

(d) Coverage for one hundred percent of the medicare Part B deductible amount per calendar year regardless of hospital confinement.

(e) Coverage for all of the difference between the actual medicare Part B charges as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(f) Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(4)(a) Every issuer of a standardized medicare supplement plan B, C, D, F, F with high deductible, G, K, L, M, or N issued on or after June 1, 2010, must issue to an individual who was eligible for both medicare hospital and physician services prior to January 1, 2020, without evidence of insurability, coverage under a 2010 plan B, C, D, F, F with high deductible, G, G with high deductible, K, L, M, or N to any policyholder if the medicare supplement policy or certificate re-

places another medicare supplement policy or certificate B, C, D, F, F with high deductible, G, G with high deductible, K, L, M, or N or other more comprehensive coverage, including any standardized medicare supplement policy issued prior to June 1, 2010.

(b) Every issuer of a standardized medicare supplemental plan B, D, G, G with high deductible, K, L, M, or N issued on or after January 1, 2020, must issue to an individual who was eligible for both medicare hospital and physician services on or after January 1, 2020, without evidence of insurability, coverage under a 2010 plan B, D, G, G with high deductible, K, L, M, or N to any policyholder if the medicare supplemental policy or certificate replaces another medicare supplemental policy or certificate B, D, G, G with high deductible, K, L, M, or N or other more comprehensive coverage.

(c) Every issuer of a standardized medicare supplement plan A issued on or after June 1, 2010, must issue, without evidence of insurability, coverage under a 2010 plan A to any policyholder if the medicare supplement policy or certificate replaces another medicare supplement plan A issued prior to June 1, 2010.

AMENDATORY SECTION (Amending WSR 09-24-052, filed 11/24/09, effective 1/19/10)

WAC 284-66-067 Standard medicare supplement plans issued for delivery on or after June 1, 2010. No policy or certificate delivered or issued for delivery in this state on or after June 1, 2010, as a medicare supplement policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-066.

(1)(a) An issuer must make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic or core benefits, as defined in WAC 284-66-064.

(b) If an issuer makes available any of the additional benefits described in WAC 284-66-064 or offers standardized benefit plan K or L as described in subsection (5) of this section, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic or core benefits as described in (a) of this ((~~section~~)) subsection, a policy form or certificate form containing either standardized benefit plan C or standardized benefit plan F.

(2) No groups, packages or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in WAC 284-66-064 and 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this section and conform to the definitions in this chapter. Each benefit must be structured in accordance with the format found in WAC 284-66-064 or in the case of plans K or L, in subsection (5) of this section, and list the benefits in the order shown. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(4) In addition to the benefit plan designations required in subsection (3) of this section, an issuer may use other designations to the extent permitted by law.

(5) Make-up of 2010 standardized benefit plans:

(a) Standardized medicare supplement benefit plan A may include only the basic core benefits as defined in WAC 284-66-064.

(b) Standardized medicare supplement benefit plan B may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible as defined in WAC 284-66-064.

(c) Standardized medicare supplement benefit plan C may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(d) Standardized medicare supplement benefit plan D may include only the basic core benefits as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(e) Standardized medicare supplement regular plan F may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, the skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(f) Standardized medicare supplement plan F with high deductible may include only one hundred percent of covered expenses following the payment of the annual deductible set forth in (f)(ii) of this subsection.

(i) The basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(ii) The annual deductible in plan F with high deductible must consist only of out-of-pocket expenses, other than premiums, for services covered by regular plan F and must be in addition to any other specific benefit deductibles. The basis for the deductible must be one thousand five hundred dollars and will be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(g) Standardized medicare supplement benefit plan G may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B excess charges and medically necessary emergency care in a foreign country as defined in WAC 284-66-064. Effective January 1, 2020, the standardized benefit plans described in WAC 284-66-068 (1)(d) (redesignated plan G high deductible) may be offered to any individual who was eligible for medicare prior to January 1, 2020.

(h) Standardized medicare supplement benefit plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and may include only the following:

(i) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any medicare benefit period;

(ii) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the 91st through the 150th day in any medicare benefit period;

(iii) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the insurer's payment as payment in full and may not bill the insured for any balance;

(iv) Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(v) Skilled nursing facility care coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vi) Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vii) Coverage for fifty percent under medicare Part A or B of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(viii) Except for coverage provided in (h)(ix) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(ix) Coverage of one hundred percent of the cost sharing for medicare Part B preventive services after the policyholder pays the Part B deductible; and

(x) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(i) Standardized medicare supplement plan L as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 may include only the following:

(i) The benefits described in (h)(i) through (vi) and (ix) of this subsection; and

(ii) The benefit described in (h)(i) through (vi) and (vii) of this subsection but substituting seventy-five percent for fifty percent; and

(iii) The benefit described in (h)(x) of this subsection but substituting two thousand dollars for four thousand dollars.

(j) Standardized medicare supplement plan M may include only the basic core benefit as defined in WAC 284-66-064, plus fifty percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(k) Standardized medicare supplement plan N may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (3) of this section, with copayments in the following amounts:

(i) The lesser of twenty dollars or the medicare coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists Part B; and

(ii) The lesser of fifty dollars or the medicare Part B coinsurance of copayment for each covered emergency room visit, however this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare Part A expense.

(6) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of medicare supplement simplification. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

AMENDATORY SECTION (Amending WSR 09-05-004, filed 2/4/09, effective 3/7/09)

WAC 284-66-068 ~~((Prohibition against use of genetic information and requests for genetic testing.))~~ Standard medicare supplemental plans issued for delivery to individuals newly eligible for medicare on or after January 1, 2020. ~~((Effective May 21, 2009, except as provided in subsection (3) of this section:~~

~~(1) An issuer of a medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. This includes the imposition of any exclusion of benefits under the policy based on a preexisting condition or adjustment of premium rates based on genetic information. This subsection shall not be construed to limit the ability of an issuer, to the extent otherwise permitted by law from:~~

~~(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium based on the manifestation of a disease or disorder of the insured or applicant; or~~

~~(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual must not be used as genetic information about other group members or to increase the premium for the group.~~

~~(2) An issuer of a medicare supplement insurance policy or certificate must not request or require an individual or a family member of the individual to undergo a genetic test. This subsection shall not be construed to preclude an issuer from obtaining and using the results of a genetic test in making a determination regarding payment consistent with subsection (1) of this section. For purposes of this section, "payment" has the meaning set forth in Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time. An issuer may request only the minimum information necessary to accomplish the intended purpose.~~

~~(3) An issuer may request, but must not require, that an individual or a family member of the individual undergo a genetic test only if all of the following conditions are met:~~

~~(a) The request is made for research that complies with Part 46 of Title 45, Code of Federal Regulations, or its equivalent, or any other applicable state or local law or rule for the protection of human subjects in research;~~

~~(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:~~

~~(i) Compliance with the request is voluntary; and~~

~~(ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;~~

~~(c) Genetic information collected or acquired under this subsection must not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;~~

~~(d) The issuer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted;~~

~~(e) The issuer complies with all other conditions required by regulation by the secretary of the United States Department of Health and Human Services for activities conducted under this subsection;~~

~~(4) An issuer must not request, require, or purchase genetic information for underwriting purposes;~~

~~(5) An issuer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment; and~~

~~(6) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase will not be considered a violation of subsection (5) of this section only if the request, requirement, or purchase is not in violation of subsection (4) of this section.~~

~~(7) For purposes of this section:~~

~~(a) "Issuer" has the meaning set forth in WAC 284-66-030(4) and includes any third-party administrator or other person acting for or on behalf of the issuer.~~

~~(b) "Family member" means any individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.~~

~~(c) "Genetic information" means information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members. The term includes any requests for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or a family member. Any reference to genetic information concerning an individual or family member who is a pregnant woman includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the gender or age of any individual.~~

~~(d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.~~

~~(e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.~~

~~(f) "Underwriting purposes" means:~~

~~(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;~~

~~(ii) The computation of premium or contribution amounts under the policy;~~

~~(iii) The application of any preexisting condition exclusion under the policy; and~~

~~(iv) Other activities related to the creation, renewal, or replacement of a policy of health insurance or health benefits.~~)) The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all medicare supplemental policies or certificates delivered or issued for delivery in the state to individuals newly eligible for medicare on or after January 1, 2020. No policy or certificate that provides coverage of the medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplemental policy or certificate to individuals newly eligible for medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards to medicare supplemental policies and certificates issued to individuals eligible for medicare before January 1, 2020, remain subject to the requirements of WAC 284-66-067.

(1) Benefit requirements. The standards and requirements of WAC 284-66-067 shall apply to all medicare supplemental policies or certificates delivered or issued for delivery to those newly eligible for medicare on or after January 1, 2020, with the following exceptions:

(a) Standardized medicare supplemental benefit plan C is redesignated as plan D and must provide the benefits contained in WAC 284-66-067 (5)(c) but shall not provide coverage for one hundred percent or any portion of the medicare Part B deductible;

(b) Standardized medicare supplemental benefit plan F is redesignated as plan G and must provide the benefits contained in WAC 284-66-067 (5)(e) but shall not provide coverage for one hundred percent or any portion of the medicare Part B deductible;

(c) Standardized medicare supplemental plans C, F, and F with high deductible may not be offered to individuals newly eligible for medicare on or after January 1, 2020;

(d) Standardized medicare supplemental benefit plan F with high deductible is redesignated as plan G with high deductible and must provide the benefits contained in WAC 284-66-067 (5)(f) but shall not provide coverage for one hundred percent or any portion of the medicare Part B deductible; provided further that, the medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible; and

(e) The reference to plans C or F contained in WAC 284-66-067 (1)(b) is deemed a reference to plans D or G for purposes of this section.

(2) Applicability to certain individuals. This section applies only to individuals that are newly eligible for medicare on or after January 1, 2020:

(a) By reason of attaining age sixty-five on or after January 1, 2020; or

(b) By reason of entitlement to benefits under Part A under section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(3) Offer of redesignated plans to individuals other than newly eligible. On or after January 1, 2020, the standardized benefit plans described in subsection (1)(d) of this section may be offered to any individual who was eligible for medicare prior to January 1, 2020, in addition to the standardized plans described in WAC 284-66-067.

NEW SECTION

WAC 284-66-071 Prohibition against use of genetic information and requests for genetic testing. Effective May 21, 2009, except as provided in subsection (3) of this section:

(1) An issuer of a medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. This includes the imposition of any exclusion of benefits under the policy based on a preexisting condition or adjustment of premium rates based on genetic information. This subsection shall not be construed to limit the ability of an issuer, to the extent otherwise permitted by law from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium based on the manifestation of a disease or disorder of the insured or applicant; or

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual must not be used as genetic information about other group members or to increase the premium for the group.

(2) An issuer of a medicare supplement insurance policy or certificate must not request or require an individual or a family member of the individual to undergo a genetic test. This subsection shall not be construed to preclude an issuer from obtaining and using the results of a genetic test in making a determination regarding payment consistent with subsection (1) of this section. For purposes of this section, "payment" has the meaning set forth in Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time. An issuer may request only the minimum information necessary to accomplish the intended purpose.

(3) An issuer may request, but must not require, that an individual or a family member of the individual undergo a genetic test only if all of the following conditions are met:

(a) The request is made for research that complies with Part 46 of Title 45, Code of Federal Regulations, or its equivalent, or any other applicable state or local law or rule for the protection of human subjects in research;

(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(i) Compliance with the request is voluntary; and

(ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Genetic information collected or acquired under this subsection must not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(d) The issuer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted;

(e) The issuer complies with all other conditions required by regulation by the secretary of the United States Department of Health and Human Services for activities conducted under this subsection;

(4) An issuer must not request, require, or purchase genetic information for underwriting purposes;

(5) An issuer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment; and

(6) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase will not be considered a violation of subsection (5) of this section only if the request, requirement, or purchase is not in violation of subsection (4) of this section.

(7) For purposes of this section:

(a) "Issuer" has the meaning set forth in WAC 284-66-030(4) and includes any third-party administrator or other person acting for or on behalf of the issuer.

(b) "Family member" means any individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(c) "Genetic information" means information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members. The term includes any requests for or receipt of genetic serv-

ices or participation in clinical research which includes genetic services by the individual or a family member. Any reference to genetic information concerning an individual or family member who is a pregnant woman includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the gender or age of any individual.

(d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(f) "Underwriting purposes" means:

(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) The computation of premium or contribution amounts under the policy;

(iii) The application of any preexisting condition exclusion under the policy; and

(iv) Other activities related to the creation, renewal, or replacement of a policy of health insurance or health benefits.

AMENDATORY SECTION (Amending WSR 11-01-159, filed 12/22/10, effective 1/22/11)

WAC 284-66-130 Requirements for application forms and replacement of medicare supplement insurance coverage. (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another medicare supplement, medicare advantage, medicaid coverage, or another health insurance or other disability policy or certificate in force or whether a medicare supplement insurance policy or certificate is intended to replace any other policy or certificate of a health care service contractor, health maintenance organization, disability insurer, or fraternal benefit society presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing the questions and statements, may be used: If the coverage is sold without an insurance producer, the supplementary application must be signed by the applicant.

[Statements]

(1) You do not need more than one medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are sixty-five or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for medicaid, the benefits and premiums under your medicare supplement policy can be suspended if requested during your entitlement to benefits under medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety days of losing medicaid eligibility. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medical assistance through the state medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

[Please mark Yes or No below with an "X"]

To the best of your knowledge.

(1)(a) Did you turn age 65 in the last 6 months?

Yes □ No □

(b) Did you enroll in medicare Part B in the last 6 months?

Yes □ No □

(c) If yes, what is the effective date?

(2) Are you covered for medical assistance through the state medicaid program?

[NOTE TO APPLICANT; If you are participating in a "Spend - Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes □ No □

If yes,

(a) Will medicaid pay your premiums for this medicare supplement policy?

Yes □ No □

(b) Do you receive any benefits from medicaid OTHER THAN payments toward your medicare Part B premium?

Yes □ No □

(3)(a) If you had coverage from any medicare plan other than original medicare within the past 63 days (for example, a medicare advantage plan, or a medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START // END //

(b) If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy?

Yes □ No □

(c) Was this your first time in this type of medicare plan?

Yes □ No □

(d) Did you drop a medicare supplement policy to enroll in the medicare plan?

Yes □ No □

(4)(a) Do you have another medicare supplement policy in force?

Yes □ No □

(b) If so, with what company and what plan do you have [optional for Direct Mailers]?

_____

_____

_____

(c) If so, do you intend to replace your current medicare supplement policy with this policy?

Yes □ No □

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.)

Yes □ No □

(a) If so, with what company and what kind of policy?

_____

_____

(b) What are your dates of coverage under the other policy?

START // END //

(If you are still covered under the other policy, leave "END" blank.)

(2) Insurance producers must list any other medical or health insurance policies sold to the applicant.

(a) List policies sold that are still in force.

(b) List policies sold in the past five years that are no longer in force.

(3) Immediately adjacent to the section of the application on which the applicant chooses the plan type for which they are applying, the company must include the following language, in bold type: "Only those applicants who are initially eligible for Medicare before January 1, 2020 may apply for plans C, F, and high deductible F, if offered."

(4) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy.

((~~(4)~~)) (5) Upon determining that a sale will involve replacement of medicare supplement coverage, an issuer, other than a direct response issuer, or its appointed insurance producer, must furnish the applicant, before issuing or delivering the medicare supplement insurance policy or certificate, a notice regarding replacement of medicare supplement insurance coverage. One copy of the notice, signed by the applicant and the insurance producer (except where the coverage is sold without an insurance producer), must be provided to the applicant and an additional signed copy must be kept by the issuer. A direct response issuer must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement insurance coverage.

((~~(5)~~)) (6) The notice required by subsection ((~~(4)~~)) (5) of this section for an issuer, must be provided in substantially the form set forth in WAC 284-66-142 in no smaller than twelve point type, and must be filed with the commissioner before being used in this state.

((~~(6)~~)) (7) The notice required by subsection ((~~(4)~~)) (5) of this section for a direct response insurer must be in substantially the form set forth in WAC 284-66-142 and must be filed with the commissioner before being used in this state.

((~~(7)~~)) (8) A true copy of the application for a medicare supplement insurance policy issued by a health maintenance organization or health care service contractor for delivery to a resident of this state must be attached to or otherwise physically made a part of the policy when issued and delivered.

((~~(8)~~)) (9) Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization may substitute appropriate terminology.

((~~(9)~~)) (10) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.