

commission makes such a finding, it may require the private shared telecommunications services provider to make alternative facilities or conduit space available on reasonable terms and conditions at reasonable prices((-));

(6) Radio communications services provided by a regulated telecommunications company, except that when those services are the only voice grade, local exchange telecommunications service available to a customer of the company the commission may regulate the radio communication service of that company.

Passed the House March 5, 1990.

Passed the Senate March 2, 1990.

Approved by the Governor March 21, 1990.

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CHAPTER 119

[Substitute House Bill No. 3001]

HEALTH MAINTENANCE ORGANIZATIONS—SOLVENCY PROTECTION

AN ACT Relating to solvency protection for health maintenance organizations; amending RCW 48.46.020, 48.46.030, 48.46.040, 48.46.240, 48.46.420, and 48.80.030; adding new sections to chapter 48.46 RCW; repealing RCW 48.46.230; and prescribing penalties.

Be it enacted by the Legislature of the State of Washington:

Sec. 1. Section 3, chapter 290, Laws of 1975 1st ex. sess. as last amended by section 1, chapter 106, Laws of 1983 and RCW 48.46.020 are each amended to read as follows:

As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Health maintenance organization" means any organization receiving a certificate of ((authority)) registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(2) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(3) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(4) "Health professionals" means health care practitioners who are (~~licensed under the provisions of chapters 18.22, 18.25, 18.29, 18.32, 18.34, 18.53, 18.57, 18.57A, 18.64, 18.71, 18.71A, 18.74, 18.78, 18.83, or 18.88 RCW~~) regulated by the state of Washington.

(5) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(6) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or shareholders of stock corporations licensed as health maintenance organizations.

(7) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(8) "Meaningful grievance procedure" means a procedure for investigation of consumer grievances in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures.

(9) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

(10) "Department" means the state department of social and health services.

(11) "Commissioner" means the insurance commissioner.

(12) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

(13) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

(14) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are ((covered by a)) the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization.

(15) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(16) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(17) "Fully subordinated debt" means those debts that meet the requirements of section 5(3) of this act and are recorded as equity.

(18) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(19) "Participating provider" means a provider as defined in subsection (9) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(20) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual agreement.

(21) "Replacement coverage" means the benefits provided by a succeeding carrier.

(22) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

Sec. 2. Section 4, chapter 290, Laws of 1975 1st ex. sess. as last amended by section 1, chapter 320, Laws of 1985 and RCW 48.46.030 are each amended to read as follows:

Any corporation, cooperative group, partnership, individual, association, or groups of health professionals licensed by the state of Washington, public hospital district, or public institutions of higher education shall be entitled to a certificate of registration from the insurance commissioner as a health maintenance organization if it:

(1) Provides comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provides such health services either directly or through arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health; and

(2) Is governed by a board elected by enrolled participants, or otherwise provides its enrolled participants with a meaningful role in policy making procedures of such organization, as defined in RCW 48.46.020(7), and 48.46.070; and

(3) Affords enrolled participants with a meaningful grievance procedure aimed at settlement of disputes between such persons and such health maintenance organization, as defined in RCW 48.46.020(8) and 48.46.100; and

(4) Provides enrolled participants, or makes available for inspection at least annually, financial statements pertaining to health maintenance agreements, disclosing income and expenses, assets and liabilities, and the bases for proposed rate adjustments for health maintenance agreements relating to its activity as a health maintenance organization; and

(5) Demonstrates to the satisfaction of the commissioner that its facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants and that it is financially capable of providing such members with, or has made adequate contractual arrangements through insurance or otherwise to provide such members with, such health services; and

(6) Substantially complies with administrative rules and regulations of the commissioner for purposes of this chapter; and

(7) Submits an application for a certificate of registration which shall be verified by an officer or authorized representative of the applicant, being in form as the commissioner prescribes, and setting forth:

(a) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar documents, if any, which regulate the conduct of the internal affairs of the applicant, and all amendments thereto;

(c) A list of the names, addresses, members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers, partners, or members;

(d) A full and complete disclosure of any financial interests held by any officer, or director in any provider associated with the applicant or any provider of the applicant;

(e) A description of the health maintenance organization, its facilities and its personnel, and the applicant's most recent financial statement showing such organization's assets, liabilities, income, and other sources of financial support;

(f) A description of the geographic areas and the population groups to be served and the size and composition of the anticipated enrollee population;

(g) A copy of each type of health maintenance agreement to be issued to enrolled participants;

(h) A schedule of all proposed rates of reimbursement to contracting health care facilities or providers, if any, and a schedule of the proposed charges for enrollee coverage for health care services, accompanied by data relevant to the formulation of such schedules;

(i) A description of the proposed method and schedule for soliciting enrollment in the applicant health maintenance organization and the basis of compensation for such solicitation services;

(j) A copy of the solicitation document to be distributed to all prospective enrolled participants in connection with any solicitation;

(k) A financial projection which sets forth the anticipated results during the initial two years of operation of such organization, accompanied by a summary of the assumptions and relevant data upon which the projection is based. The projection should include the projected expenses, enrollment trends, income, enrollee utilization patterns, and sources of working capital;

(l) A detailed description of the enrollee complaint system as provided by RCW 48.46.100;

(m) A detailed description of the procedures and programs to be implemented to assure that the health care services delivered to enrolled participants will be of professional quality; ~~(and)~~

(n) A detailed description of procedures to be implemented to meet the requirements to protect against insolvency in section 8 of this act;

(o) Documentation that the health maintenance organization has an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under section 5 of this act; and

(p) Such other information as the commissioner shall require by rule or regulation which is reasonably necessary to carry out the provisions of this section.

A health maintenance organization shall, unless otherwise provided for in this chapter, file a notice describing any modification of any of the information required by subsection (7) of this section. Such notice shall be filed with the commissioner.

Sec. 3. Section 5, chapter 290, Laws of 1975 1st ex. sess. as last amended by section 223, chapter 9, Laws of 1989 1st ex. sess. and RCW 48.46.040 are each amended to read as follows:

The commissioner shall issue a certificate of registration to the applicant within sixty days of such filing unless he notifies the applicant within such time that such application is not complete and the reasons therefor; or that he is not satisfied that:

(1) The basic organizational document of the applicant permits the applicant to conduct business as a health maintenance organization;

(2) The organization has demonstrated the intent and ability to assure that comprehensive health care services will be provided in a manner to assure both their availability and accessibility;

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination, the commissioner shall consider among other relevant factors:

(a) Any agreements with an insurer, a medical or hospital service bureau, a government agency or any other organization paying or insuring payment for health care services;

(b) Any agreements with providers for the provision of health care services; ~~(and)~~

(c) Any arrangements for liability and malpractice insurance coverage; and

(d) Adequate procedures to be implemented to meet the protection against insolvency requirements in section 8 of this act.

(4) The procedures for offering health care services and offering or terminating contracts with enrolled participants are reasonable and equitable in comparison with prevailing health insurance subscription practices and health maintenance organization enrollment procedures; and, that

(5) Procedures have been established to:

(a) Monitor the quality of care provided by such organization, including, as a minimum, procedures for internal peer review;

(b) Resolve complaints and grievances initiated by enrolled participants in accordance with RCW 48.46.010 and 48.46.100;

(c) Offer enrolled participants an opportunity to participate in matters of policy and operation in accordance with RCW 48.46.020(7) and 48.46.070.

No person to whom a certificate of registration has not been issued, except a health maintenance organization certified by the secretary of the department of health ~~(, education and welfare)~~ and human services, pursuant to Public Law 93-222 or its successor, shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts, or literature. Persons who are contracting with, operating in association with, recruiting enrolled participants for, or otherwise authorized by a health maintenance organization possessing a certificate of registration to act on its behalf may use the terms "health maintenance organization" or "HMO"

for the limited purpose of denoting or explaining their relationship to such health maintenance organization.

The department of health, at the request of the insurance commissioner, shall inspect and review the facilities of every applicant health maintenance organization to determine that such facilities are reasonably adequate to provide the health care services offered in their contracts. If the commissioner has information to indicate that such facilities fail to continue to be adequate to provide the health care services offered, the department of health, upon request of the insurance commissioner, shall reinspect and review the facilities and report to the insurance commissioner as to their adequacy or inadequacy.

NEW SECTION. Sec. 4. A new section is added to chapter 48.46 RCW to read as follows:

(1) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080. Enrolled participants shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrolled participants and enrolled participants' beneficiaries shall have the same priority as established by RCW 48.31.280 for policyholders and beneficiaries of insureds of insurance companies. If an enrolled participant is liable to any provider for services provided pursuant to and covered by the health maintenance agreement, that liability shall have the status of an enrolled participant claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled participants harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrolled participants and enrolled participants' beneficiaries as described herein, and immediately preceding the priority of distribution described in RCW 48.31.280(2)(e).

NEW SECTION. Sec. 5. A new section is added to chapter 48.46 RCW to read as follows:

(1) Except as provided in subsection (2) of this section, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(a) One million dollars; or

(b) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first

one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars; or

(c) An amount equal to the sum of three months' uncovered expenditures as reported on the most recent financial statement filed with the commissioner.

(2) A health maintenance organization registered before the effective date of this act, must maintain a minimum net worth of:

(a) Twenty-five percent of the amount required by subsection (1) of this section by December 31, 1990;

(b) Fifty percent of the amount required by subsection (1) of this section by December 31, 1991;

(c) Seventy-five percent of the amount required by subsection (1) of this section by December 31, 1992; and

(d) One hundred percent of the amount required by subsection (1) of this section by December 31, 1993.

(3)(a) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. An interest obligation relating to the repayment of a subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of a fully subordinated debt shall not be considered uncovered expenditures.

(c) A subordinated debt incurred by a note meeting the requirement of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(4) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

Such liabilities shall be computed in accordance with rules promulgated by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

Sec. 6. Section 3, chapter 151, Laws of 1982 as amended by section 4, chapter 320, Laws of 1985 and RCW 48.46.240 are each amended to read as follows:

(1) Each health maintenance organization obtaining a certificate of ~~((authority))~~ registration from the commissioner shall provide and maintain a funded reserve of one hundred fifty thousand dollars ~~((, which shall be in addition to any deposit or contingent reserve requirements set forth in RCW 48.46.230))~~. The funded reserve shall be deposited with the commissioner or with any organization/trustee acceptable to him in the form of cash, securities eligible for investment by the health maintenance organization pursuant to chapter 48.13 RCW, approved surety bond or any combination of

these ((or other measures that are acceptable to the commissioner)), and must equal or exceed one hundred fifty thousand dollars. The funded reserve shall be established as ((a guarantee)) an assurance that the uncovered expenditure obligations of the health maintenance organization to the enrolled participants will be performed.

(2) ~~((Any health maintenance organization that is in operation on January 1, 1983, shall establish a funded reserve of one hundred thousand dollars within one year and accrue twenty-five thousand dollars on the first day of the second and third fiscal years following twelve months after January 1, 1983))~~ All income from reserves on deposit with the commissioner shall belong to the depositing health maintenance organization and shall be paid to it as it becomes available.

(3) Any funded reserve required by this section shall be considered an asset of the health maintenance organization in determining the organization's net worth.

(4) A health maintenance organization that has made a securities deposit with the commissioner may, at its option, withdraw the securities deposit or any part of the deposit after first having deposited or provided in lieu thereof an approved surety bond, a deposit of cash or securities, or any combination of these or other deposits of equal amount and value to that withdrawn. Any securities and surety bond shall be subject to approval by the commissioner before being substituted.

NEW SECTION. Sec. 7. A new section is added to chapter 48.46 RCW to read as follows:

(1) Subject to subsection (2) of this section, every contract between a health maintenance organization and its participating providers of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the agreement, the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization. Every such contract shall provide that this requirement shall survive termination of the contract.

(2) The provisions of subsection (1) of this section shall not apply to emergency care from a provider who is not a participating provider, to out-of-area services or, in exceptional situations approved in advance by the commissioner, if the health maintenance organization is unable to negotiate reasonable and cost-effective participating provider contracts.

(3)(a) Each participating provider contract form shall be filed with the commissioner fifteen days before it is used.

(b) Any contract form not affirmatively disapproved within fifteen days of filing shall be deemed approved, except that the commissioner may extend the approval period an additional fifteen days upon giving notice before

the expiration of the initial fifteen-day period. The commissioner may approve such a contract form for immediate use at any time. Approval may be subsequently withdrawn for cause.

(c) Subject to the right of the health maintenance organization to demand and receive a hearing under chapters 48.04 and 34.05 RCW, the commissioner may disapprove such a contract form if it is in any respect in violation of this chapter or if it fails to conform to minimum provisions or standards required by the commissioner by rule under chapter 34.05 RCW.

(4) No participating provider, or agent, trustee, or assignee thereof, may maintain an action against an enrolled participant to collect sums owed by the health maintenance organization.

NEW SECTION. Sec. 8. A new section is added to chapter 48.46 RCW to read as follows:

Each health maintenance organization shall have a plan for handling insolvency which allows for continuation of benefits for the duration of the agreement period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The commissioner shall approve such a plan if it includes:

(1) Insurance to cover the expenses to be paid for continued benefits after insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrolled participants' discharge from inpatient facilities;

(3) Use of insolvency reserves established under RCW 48.46.240;

(4) Acceptable letters of credit or approved surety bonds; or

(5) Any other arrangements the commissioner and the organization mutually agree are appropriate to assure that benefits are continued.

NEW SECTION. Sec. 9. A new section is added to chapter 48.46 RCW to read as follows:

(1)(a) In the event of insolvency of a health care service contractor or health maintenance organization and upon order of the commissioner, all other carriers then having active enrolled participants under a group plan with the affected agreement holder that participated in the enrollment process with the insolvent health care service contractor or health maintenance organization at a group's last regular enrollment period shall offer the eligible enrolled participants of the insolvent health services contractor or health maintenance organization the opportunity to enroll in an existing group plan without medical underwriting during a thirty-day open enrollment period, commencing on the date of the insolvency. Eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's group plan. An open enrollment shall not be required

where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule, unless the plan administrator and agreement holder voluntarily agree to offer a simultaneous open enrollment and extend coverage under the same enrollment terms and conditions as are applicable to carriers under this title and rules adopted under this title. If an exempt plan was offered during the last regular open enrollment period, then the carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this title for the duration of the current agreement period.

(b) For purposes of this subsection only, the term "carrier" means a health maintenance organization or a health care service contractor. In the event of insolvency of a carrier and if no other carrier has active enrolled participants under a group plan with the affected agreement holder, or if the commissioner determines that the other carriers lack sufficient health care delivery resources to assure that health services will be available or accessible to all of the group enrollees of the insolvent carrier, then the commissioner shall allocate equitably the insolvent carrier's group agreements for these groups among all carriers that operate within a portion of the insolvent carrier's area, taking into consideration the health care delivery resources of each carrier. Each carrier to which a group or groups are allocated shall offer the agreement holder, without medical underwriting, the carrier's existing coverage that is most similar to each group's coverage with the insolvent carrier at rates determined in accordance with the successor carrier's existing rating methodology. The eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's group plan. No offering by a carrier shall be required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule. The carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this title for the duration of the current agreement period.

(2) The commissioner shall also allocate equitably the insolvent carrier's nongroup enrolled participants who are unable to obtain coverage among all carriers that operate within a portion of the insolvent carrier's service area, taking into consideration the health care delivery resources of the carrier. Each carrier to which nongroup enrolled participants are allocated shall offer the nongroup enrolled participants the carrier's existing comprehensive conversion plan, without additional medical underwriting, at rates determined in accordance with the successor carrier's existing rating methodology. The eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a

preexisting condition has not been satisfied under the insolvent carrier's plan.

(3) Any agreements covering participants allocated pursuant to subsections (1)(b) and (2) of this section to carriers pursuant to this section may be rerated after ninety days of coverage.

(4) A limited health care service contractor shall not be required to offer services other than its one limited health care service to any enrolled participant of an insolvent carrier.

Sec. 10. Section 20, chapter 106, Laws of 1983 and RCW 48.46.420 are each amended to read as follows:

(1) Any health maintenance organization which, or person who, violates any provision of this chapter shall be guilty of a gross misdemeanor.

(2) A health maintenance organization that fails to comply with the net worth requirements of this chapter must cure that defect in compliance with an order of the commissioner rendered in conformity with rules adopted pursuant to chapter 34.05 RCW. The commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrolled participants.

Sec. 11. Section 3, chapter 243, Laws of 1986 and RCW 48.80.030 are each amended to read as follows:

(1) A person shall not make or present or cause to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false.

(2) No person shall knowingly present to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. Each claim that violates this subsection shall constitute a separate offense.

(3) No person shall knowingly make a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates this subsection shall constitute a separate violation.

(4) No person shall conceal the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service. A person shall not conceal or fail to disclose any information with intent to obtain a health care payment to which the person or any other person is not entitled, or to obtain a health care payment in an amount greater than that which the person or any other person is entitled.

(5) No provider shall willfully collect or attempt to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payor to which the provider is a party.

(6) A person who violates this section is guilty of a class C felony punishable under chapter 9A.20 RCW.

~~((6))~~ (7) This section does not apply to statements made on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization, or other legal entity which is self-insured and providing health care benefits to its employees.

NEW SECTION. Sec. 12. Section 2, chapter 151, Laws of 1982 and RCW 48.46.230 are each repealed.

Passed the House March 5, 1990.

Passed the Senate March 2, 1990.

Approved by the Governor March 21, 1990.

Filed in Office of Secretary of State March 21, 1990.

CHAPTER 120

[Substitute House Bill No. 3002]

HEALTH CARE SERVICE CONTRACTORS—SOLVENCY PROTECTION

AN ACT Relating to solvency protection for health care service contractors; amending RCW 48.44.010, 48.44.020, 48.44.026, 48.44.070, 48.44.080, and 48.80.030; and adding new sections to chapter 48.44 RCW.

Be it enacted by the Legislature of the State of Washington:

Sec. 1. Section 1, chapter 223, Laws of 1986 and RCW 48.44.010 are each amended to read as follows:

For the purposes of this chapter:

(1) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

(2) "Provider" means any ~~((person lawfully licensed or authorized by the state of Washington to render any health care))~~ health professional, hospital, or other institution, organization, or person that furnishes health care services and is licensed to furnish such services.

(3) "Health care service contractor" means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services.

(4) "~~((Participant))~~ Participating provider" means a provider, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services.