(((~~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 Section 2, chapter 151, Laws of 1982 and RCW 48.46.230 are each repealed.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.
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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.

(5) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health care service contractor to receive health care services.

(6) "Commissioner" means the insurance commissioner.

(7) "Uncovered expenditures" means the costs to the health care service contractor for health care services that are the obligation of the health care service contractor for which an enrolled participant would also be liable in the event of the health care service contractor'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 care service contractor, or for services that are guaranteed, insured or assumed by a person or organization other than the health care service contractor.

(8) "Copayment" means an amount specified in a group or individual contract which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(9) "Deductible" means the amount an enrolled participant is responsible to pay before the health care service contractor begins to pay the costs associated with treatment.

(10) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(11) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

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

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

(14) "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.

(15) "Fully subordinated debt" means those debts that meet the requirements of section 4(3) of this act and are recorded as equity.

(16) "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.

NEW SECTION. Sec. 2. A new section is added to chapter 48.44 RCW to read as follows:

(1) Any rehabilitation, liquidation, or conservation of a health care service contractor 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 care service contractor upon any one or more grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080.

(2) For purpose 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 care plan, that liability shall have the status of an enrolled participant claim for distribution of general assets.

(3) Any 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 chapter 48.31 RCW.

NEW SECTION. Sec. 3. A new section is added to chapter 48.44 RCW to read as follows:

(1) For purposes of this section only, "limited health care service" means dental care services, vision care services, mental health services, chemical dependency services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services, but does not include hospital, medical, surgical, emergency, or out–of–area services except as those services are provided incidentally to the limited health services set forth in this subsection.

(2) For purposes of this section only, a "limited health care service contractor" means a health care service contractor that offers one and only one limited health care service.

(3) For all limited health care service contractors that have had a certificate of registration for less than three years, their uncovered expenditures shall be either insured or guaranteed by a foreign or domestic carrier admitted in the state of Washington or by another carrier acceptable to the commissioner. All such contractors shall also deposit with the commissioner one–half of one percent of their projected premium for the next year in cash, approved surety bond, securities, or other form acceptable to the commissioner.

(4) For all limited health care service contractors that have had a certificate of registration for three years or more, their uncovered expenditures shall be assured by depositing with the insurance commissioner twenty–five percent of their last year's uncovered expenditures as reported to the commissioner and adjusted to reflect any anticipated increases or decreases

during the ensuing year plus an amount for unearned prepayments; in cash, approved surety bond, securities, or other form acceptable to the commissioner. Compliance with subsection (3) of this section shall also constitute compliance with this requirement.

(5) Limited health service contractors need not comply with section 4 or 7 of this act.

NEW SECTION. Sec. 4. A new section is added to chapter 48.44 RCW to read as follows:

(1)(a) Except as provided in subsection (2) of this section, every health care service contractor must have a net worth of one million five hundred thousand dollars at the time of initial registration under this chapter and a net worth of one million dollars thereafter. The commissioner is authorized to establish standards for reviewing a health care service contractor's financial integrity when, for any reason, its net worth is reduced below one million dollars. When satisfied that such a health care service contractor is financially stable and not hazardous to its enrolled participants, the commissioner may waive compliance with the one million dollar net worth standard otherwise required by this subsection. When such a health care service contractor's net worth falls below five hundred thousand dollars, the commissioner shall require that net worth be increased to one million dollars.

(b) A health care service contractor who fails to maintain the required net worth must cure that defect in compliance with an order of the commissioner rendered in conformity with rules adopted under chapter 34.05 RCW. The commissioner may take appropriate action to assure that the continued operation of the health care service contractor will not be hazardous to its enrolled participants.

(2) A health care service contractor registered before the effective date of this act must maintain a 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 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 care service contractor 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 which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims.

Liabilities shall be computed in accordance with regulations adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the health care service contractor.

(5) All income from reserves on deposit with the commissioner shall belong to the depositing health care service contractor and shall be paid to it as it becomes available.

(6) Any funded reserve required by this chapter shall be considered an asset of the health care service contractor in determining the organization's net worth.

(7) A health care service contractor that has made a securities deposit with the commissioner may, at its option, withdraw the securities deposit or any part thereof 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.

Sec. 5. Section 2, chapter 268, Laws of 1947 as last amended by section 2, chapter 223, Laws of 1986 and RCW 48.44.020 are each amended to read as follows:

(1) Any health care service contractor may enter into ((~~agreements~~)) contracts with or for the benefit of persons or groups of persons which require prepayment for health care services by or for such persons in consideration of such health care service contractor providing one or more health care services to such persons and such activity shall not be subject to the laws relating to insurance if the health care services are rendered by the health care service contractor or by a ((~~participant~~)) participating provider.

(2) The commissioner may on examination, subject to the right of the health care service contractor to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove any contract form for any of the following grounds:

(a) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; or

(b) If it has any title, heading or other indication of its provisions which is misleading; or

(c) If purchase of health care services thereunder is being solicited by deceptive advertising; or

(d) If, the benefits provided therein are unreasonable in relation to the amount charged for the contract;

(e) If it contains unreasonable restrictions on the treatment of patients;

(f) If it violates any provision of this chapter;

(g) If it fails to conform to minimum provisions or standards required by regulation made by the commissioner pursuant to chapter 34.05 RCW;

(h) If any contract for health care services with any state agency, division, subdivision, board or commission or with any political subdivision, municipal corporation, or quasi-municipal corporation fails to comply with state law.

(3)(a) Every contract between a health care service contractor and a participating provider of health care services shall be in writing and shall state that in the event the health care service contractor fails to pay for health care services as provided in the contract, the enrolled participant shall not be liable to the provider for sums owed by the health care service contractor. Every such contract shall provide that this requirement shall survive termination of the contract.

(b) No participating provider, agent, trustee or assignee may maintain any action against an enrolled participant to collect sums owed by the health care service contractor.

Sec. 6. Section 1, chapter 168, Laws of 1982 as last amended by section 1, chapter 122, Laws of 1989 and RCW 48.44.026 are each amended to read as follows:

Checks in payment for claims pursuant to any health care service contract for health care services provided by persons licensed or regulated under chapters 18.22, 18.25, 18.29, 18.32, 18.53, 18.57, 18.64, 18.71, 18.73, 18.74, 18.83, or 18.88 RCW, where the provider is not a ((~~participant~~)) participating provider under a contract with the health care service contractor, shall be made out to both the provider and the ((~~insured~~)) enrolled participant with the provider as the first named payee, jointly, to require endorsement by each: PROVIDED, That payment shall be made in the single name of the ((~~insured~~)) enrolled participant if the ((~~insured~~)) enrolled participant as part of his or her claim furnishes evidence of prepayment to the health care service provider: AND PROVIDED FURTHER, That nothing in this section shall preclude a health care service contractor from voluntarily issuing payment in the single name of the provider.

Sec. 7. Section 3, chapter 268, Laws of 1947 as last amended by section 3, chapter 223, Laws of 1986 and RCW 48.44.030 are each amended to read as follows:

If any of the health care services which are promised in any such agreement are not to be performed by the health care service contractor, or by a ((~~participant~~)) participating provider, such activity shall not be subject to the laws relating to insurance, provided provision is made for reimbursement or indemnity of the persons who have previously paid, or on whose behalf prepayment has been made, for such services. Such reimbursement or indemnity shall either be underwritten by an insurance company authorized to write accident, health and disability insurance in the state or guaranteed by a surety company authorized to do business in this state, or guaranteed by a deposit of cash or securities eligible for investment by insurers pursuant to chapter 48.13 RCW, with the insurance commissioner, as hereinafter provided. If the reimbursement or indemnity is underwritten by an insurance company, the contract or policy of insurance may designate the health care service contractor as the named insured, but shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services. If the reimbursement or indemnity is guaranteed by a surety company, the surety bond shall designate the state of Washington as the named obligee, but shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services, and shall be in such amount as the insurance commissioner shall direct, but in no event in a sum greater than the amount of one hundred fifty thousand dollars or the amount necessary to cover incurred but unpaid reimbursement or indemnity benefits as reported in the last annual statement filed with the insurance commissioner, and adjusted to reflect known or anticipated increases or decreases during the ensuing year, plus an amount of unearned prepayments applicable to reimbursement or indemnity benefits satisfactory to the insurance commissioner, whichever amount is greater. A copy of such insurance policy or surety bond, as the case may be, and any modification thereof, shall be filed with the insurance commissioner. If the reimbursement or indemnity is guaranteed by a deposit of cash or securities, such deposit shall be in such amount as the insurance commissioner shall direct, but in no event in a sum greater than the amount of one hundred fifty thousand dollars or the amount necessary to cover incurred but unpaid reimbursement or indemnity benefits as reported in the last annual statement filed with the insurance commissioner, and adjusted to reflect known or anticipated increases or decreases during the ensuing year, plus an amount of unearned prepayments applicable to reimbursement or indemnity benefits satisfactory to the insurance commissioner, whichever amount is greater. Such cash or security deposit shall be held in trust by the insurance commissioner and shall be for the benefit of the persons who have previously paid, or on whose behalf prepayment has been made, for such health care services.

NEW SECTION. Sec. 8. A new section is added to chapter 48.44 RCW to read as follows:

(1)(a) In the event of insolvency of a health services 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 services 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 services 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. 9. Section 4, chapter 197, Laws of 1961 as amended by section 2, chapter 87, Laws of 1965 and RCW 48.44.070 are each amended to read as follows:

(1) Forms of contracts between health care service contractors and ((~~participants~~)) participating providers shall be filed with the insurance commissioner prior to use.

(2) 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.

(3) Subject to the right of the health care service contractor 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.

Sec. 10. Section 5, chapter 197, Laws of 1961 as last amended by section 4, chapter 223, Laws of 1986 and RCW 48.44.080 are each amended to read as follows:

Every health care service contractor shall file with its annual statement with the insurance commissioner a master list of the ((~~participants~~)) participating providers with whom or with which such health care service contractor has executed contracts of participation, certifying that each such ((~~participant~~)) participating provider has executed such contract of participation. The health care service contractor shall on the first day of each month notify the insurance commissioner in writing in case of the termination of any such contract, and of any ((~~participant~~)) participating provider who has entered into a participating contract during the preceding month.

NEW SECTION. Sec. 11. A new section is added to chapter 48.44 RCW to read as follows:

Each health care service contractor shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract 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 care service contractor's insolvency for which premium payment has been made and until the enrolled participants are discharged from inpatient facilities;

(3) Use of insolvency reserves established under RCW 48.44.030;

(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 the benefits are continued.

Passed the House March 5, 1990.
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CHAPTER 121

[Senate Bill No. 6388]

INSURERS AND AGENTS—CANCELLATION OF CONTRACTS BETWEEN

AN ACT Relating to cancellation of contracts between insurers and agents; adding a new section to chapter 48.17 RCW; and repealing RCW 48.17.590.

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

NEW SECTION. Sec. 1. A new section is added to chapter 48.17 RCW to read as follows: