2279-S AMC CONF H3329.1

SHB 2279 - CONF REPT
By Conference Committee

SEN FAILED TO ADOPT 4/25/97

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 70.47.015 and 1995 c 265 s 1 are each amended to read as follows:

(1) The legislature finds that the basic health plan has been an effective program in providing health coverage for uninsured residents. Further, since 1993, substantial amounts of public funds have been allocated for subsidized basic health plan enrollment.

(2) It is the intent of the legislature that the basic health plan enrollment be expanded expeditiously, consistent with funds available in the health services account, with the goal of two hundred thousand adult subsidized basic health plan enrollees and one hundred thirty thousand children covered through expanded medical assistance services by June 30, 1997, with the priority of providing needed health services to children in conjunction with other public programs.

(3) Effective January 1, 1996, basic health plan enrollees whose income is less than one hundred twenty-five percent of the federal poverty level shall pay at least a ten-dollar premium share.

(4) No later than July 1, 1996, the administrator shall implement procedures whereby hospitals licensed under chapters 70.41 and 71.12 RCW, health carrier, rural health care facilities regulated under chapter 70.175 RCW, and community and migrant health centers funded under RCW 41.05.220, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process.

(5) No later than July 1, 1996, the administrator shall implement procedures whereby health insurance agents and brokers, licensed under chapter 48.17 RCW, may expeditiously assist patients and their families

in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. Brokers and agents ((~~shall be entitled to~~)) may receive a commission for each individual sale of the basic health plan to anyone not ((~~at anytime previously~~)) signed up within the previous five years and a commission for each group sale of the basic health plan, if funding for this purpose is provided in a specific appropriation to the health care authority. No commission shall be provided upon a renewal. Commissions shall be determined based on the estimated annual cost of the basic health plan, however, commissions shall not result in a reduction in the premium amount paid to health carriers. For purposes of this section "health carrier" is as defined in RCW 48.43.005. The administrator may establish: (a) Minimum educational requirements that must be completed by the agents or brokers; (b) an appointment process for agents or brokers marketing the basic health plan; or (c) standards for revocation of the appointment of an agent or broker to submit applications for cause, including untrustworthy or incompetent conduct or harm to the public. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process.

Sec. 2. RCW 70.47.060 and 1995 c 266 s 1 and 1995 c 2 s 4 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive ((~~[covered basic health care services]~~)) covered basic health care services in return for premium

payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative

cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator((~~, but in no case shall the payment made on behalf of the enrollee exceed the total premiums due from the enrollee~~)).

(d) To develop, as an offering by all health carriers providing coverage identical to the basic health plan, a model plan benefits package with uniformity in enrollee cost-sharing requirements.

(3) To design and implement a structure of enrollee cost sharing due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make

suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If, as a result of an eligibility review, the administrator determines that a subsidized enrollee's income exceeds twice the federal poverty level and that the enrollee knowingly failed to inform the plan of such increase in income, the administrator may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the federal poverty level. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

(10) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by

the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance

commissioner and the department of health, to minimize duplication of effort.

(13) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

NEW SECTION. **Sec. 3.** A new section is added to chapter 70.47 RCW to read as follows:

The authority shall establish a health care savings account and catastrophic insurance pilot project for a four-year period to be offered to nonsubsidized enrollees in a basic health plan model. To the extent possible, the covered services should be similar to those in the basic health plan offered to nonsubsidized enrollees not participating in the pilot project. Requirements on eligibility, enrollee financial participation, and account management and use may be similar to the provisions of the federal medical savings account program of the federal health insurance portability and accountability act of 1996 (Part C, Title III, section 301), as amended. The authority shall contract with an actuarial firm to develop the pilot project. The firm must have extensive knowledge of the operations of health care savings accounts coverage and must have performed actuarial analyses for, at least, one hundred million dollars of health care savings account coverage and programs. The authority shall offer the pilot project no later than October 1, 1998. The authority shall conduct an evaluation on the pilot project's effectiveness and report its finding to the appropriate committees of the legislature by December 31, 2001. Except for start-up costs including program development and procurement, the full cost of the pilot project, including administration, marketing, and evaluation, is to be incurred by enrollee premiums and no additional cost is to be incurred by the state. The authority may use grants and gifts for the purpose of supporting program development and operation.

Sec. 4. RCW 48.43.025 and 1997 c . . . s 203 (Engrossed Substitute House Bill No. 2018) are each amended to read as follows:

(1) Except as permitted in RCW 48.43.035 or otherwise specified in this section ((~~and in RCW 48.43.035~~)):

(a) No carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual.

(b) No carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that a carrier may impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage.

(c) Every health carrier offering any individual health plan to any individual must allow open enrollment to eligible applicants into all individual health plans offered by the carrier during the full months of July and August of each year. The individual health plans exempt from guaranteed continuity under RCW 48.43.035(4) are exempt from this requirement. All applications for open enrollment coverage must be complete and postmarked to or received by the carrier in the months of July or August in any year following July 27, 1997. Coverage for these applicants must begin the first day of the next month subject to receipt of timely payment consistent with the terms of the policies.

(d) At any time other than the open enrollment period specified in (c) of this subsection, a carrier may either decline to accept an applicant for enrollment or apply to such applicant's coverage a preexisting condition benefit waiting period not to exceed the amount of time remaining until the next open enrollment period, or three months, whichever is greater, provided that in either case all of the following conditions are met:

(i) The applicant has not maintained coverage as required in (f) of this subsection;

(ii) The applicant is not applying as a newly eligible dependent meeting the requirements of (g) of this subsection; and

(iii) The carrier uses uniform health evaluation criteria and practices among all individual health plans it offers.

(e) If a carrier exercises the options specified in (d) of this subsection it must advise the applicant in writing within ten business days of such decision. Notice of the availability of Washington state health insurance pool coverage and a brochure outlining the benefits

and exclusions of the Washington state health insurance pool policy or policies must be provided in accordance with RCW 48.41.180 to any person rejected for individual health plan coverage, who has had any health condition limited or excluded through health underwriting or who otherwise meets requirements for notice in chapter 48.41 RCW. Provided timely and complete application is received by the pool, eligible individuals shall be enrolled in the Washington state health insurance pool in an expeditious manner as determined by the board of directors of the pool.

(f) A carrier may not refuse enrollment at any time based upon health evaluation criteria to otherwise eligible applicants who have been covered for any part of the three-month period immediately preceding the date of application for the new individual health plan under a comparable group or individual health benefit plan with substantially similar benefits. For purposes of this subsection, in addition to provisions in RCW 48.43.015, the following publicly administered coverage shall be considered comparable health benefit plans: The basic health plan established by chapter 70.47 RCW; the medical assistance program established by chapter 74.09 RCW; and the Washington state health insurance pool, established by chapter 48.41 RCW, as long as the person is continuously enrolled in the pool until the next open enrollment period. If the person is enrolled in the pool for less than three months, she or he will be credited for that period up to three months.

(g) A carrier must accept for enrollment all newly eligible dependents of an enrollee for enrollment onto the enrollee’s individual health plan at any time of the year, provided application is made within sixty-three days of eligibility, or such longer time as provided by law or contract.

(h) At no time are carriers required to accept for enrollment any individual residing outside the state of Washington, except for qualifying dependents who reside outside the carrier service area.

(2) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals or groups who are higher

than average health risks. The provisions of this section apply only to individuals who are Washington residents.

Sec. 5. RCW 48.43.035 and 1997 c . . . s 204 (Engrossed Substitute House Bill No. 2018) are each amended to read as follows:

(1) Except as permitted in RCW 48.43.025 or otherwise specified in this section ((~~and in RCW 48.43.025~~)), every health carrier shall accept for enrollment any state resident within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) Except as provided in subsection (6) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. In the case of group plans, the carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

(3) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan;

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage; or

(h) Cessation of a plan in accordance with subsection (5) or (7) of this section.

(4) The provisions of this section do not apply in the following cases:

(a) A carrier has zero enrollment on a product;

(b) A carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product; or

(c) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the insurance commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded.

(5) A health carrier may discontinue or materially modify a particular health plan, only if:

(a) The health carrier provides notice to each covered person or group provided coverage of this type of such discontinuation or modification at least ninety days prior to the date of the discontinuation or modification of coverage;

(b) The health carrier offers to each covered person <u>or group</u> provided coverage of this type the option to purchase any other health plan currently being offered by the health carrier to similar covered persons in the market category and geographic area; and

(c) In exercising the option to discontinue or modify a particular health plan and in offering the option of coverage under (b) of this subsection, the health carrier acts uniformly without regard to any health-status related factor of covered persons or persons who may become eligible for coverage.

(6) The provisions of this section do not apply to health plans deemed by the insurance commissioner to be unique or limited or have a

short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(7) A health carrier may discontinue all health plan coverage in one or more of the following lines of business:

(a)(i) Individual; or

(ii)(A) Small group (1-50 eligible employees); and

(B) Large group (51+ eligible employees);

(b) Only if:

(i) The health carrier provides notice to the office of the insurance commissioner and to each person covered by a plan within the line of business of such discontinuation at least one hundred eighty days prior to the expiration of coverage; and

(ii) All plans issued or delivered in the state by the health carrier in such line of business are discontinued, and coverage under such plans in such line of business is not renewed; and

(iii) The health carrier may not issue any health plan coverage in the line of business and state involved during the five-year period beginning on the date of the discontinuation of the last health plan not so renewed.

(8) The portability provisions of RCW 48.43.015 continue to apply to all enrollees whose health insurance coverage is modified or discontinued pursuant to this section.

(9) Nothing in this section modifies a health carrier's responsibility to offer the basic health plan model plan as required by RCW 70.47.060(2)(d).

Sec. 6. RCW 48.41.060 and 1997 c . . . s 211 (Engrossed Substitute House Bill No. 2018) are each amended to read as follows:

The board shall have the general powers and authority granted under the laws of this state to insurance companies, health care service contractors, and health maintenance organizations, licensed or registered to offer or provide the kinds of health coverage defined under this title. In addition thereto, the board may:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter including the authority, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common

administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(3) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices consistent with Washington state small group plan rating requirements under RCW ((~~48.20.028, 48.44.022, and 48.46.064~~)) 48.44.023 and 48.46.066;

(4) Assess members of the pool in accordance with the provisions of this chapter, and make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year;

(5) Issue policies of health coverage in accordance with the requirements of this chapter;

(6) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy, and other contract design, and any other function within the authority of the pool; and

(7) Conduct periodic audits to assure the general accuracy of the financial data submitted to the pool, and the board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

Sec. 7. RCW 48.41.030 and 1997 c . . . (Engrossed Substitute House Bill No. 2018) s 210 are each amended to read as follows:

HEALTH INSURANCE POOL--DEFINITIONS. As used in this chapter, the following terms have the meaning indicated, unless the context requires otherwise:

(1) "Accounting year" means a twelve-month period determined by the board for purposes of record-keeping and accounting. The first

accounting year may be more or less than twelve months and, from time to time in subsequent years, the board may order an accounting year of other than twelve months as may be required for orderly management and accounting of the pool.

(2) "Administrator" means the entity chosen by the board to administer the pool under RCW 48.41.080.

(3) "Board" means the board of directors of the pool.

(4) "Commissioner" means the insurance commissioner.

(5) "Covered Person" means any individual resident of this state who is eligible to receive benefits from any member, or other health plan.

(6) "Health care facility" has the same meaning as in RCW 70.38.025.

((~~(6)~~)) (7) "Health care provider" means any physician, facility, or health care professional, who is licensed in Washington state and entitled to reimbursement for health care services.

((~~(7)~~)) (8) "Health care services" means services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

((~~(8)~~)) (9) "Health coverage" means any group or individual disability insurance policy, health care service contract, and health maintenance agreement, except those contracts entered into for the provision of health care services pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, civilian health and medical program for the uniform services (CHAMPUS), 10 U.S.C. 55, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

((~~(9)~~)) (10) "Health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under this pool, have access to hospital and medical benefits or reimbursement including any group or individual disability insurance policy; health care service contract; health maintenance agreement; uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not

involving insurance or not governed by Title 48 RCW; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. This term includes coverage through "health coverage" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health coverage" in subsection ((~~(8)~~)) (9) of this section.

((~~(10)~~)) (11) "Medical assistance" means coverage under Title XIX of the federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and chapter 74.09 RCW.

((~~(11)~~)) (12) "Medicare" means coverage under Title XVIII of the Social Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

((~~(12)~~)) (13) "Member" means any commercial insurer which provides disability insurance, any health care service contractor, and any health maintenance organization licensed under Title 48 RCW. "Member" shall also mean, as soon as authorized by federal law, employers and other entities, including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after May 18, 1987. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products or those products excluded from the definition of "health coverage" set forth in subsection ((~~(8)~~)) (9) of this section.

((~~(13)~~)) (14) "Network provider" means a health care provider who has contracted in writing with the pool administrator to accept payment from and to look solely to the pool according to the terms of the pool health plans.

((~~(14)~~)) (15) "Plan of operation" means the pool, including articles, by-laws, and operating rules, adopted by the board pursuant to RCW 48.41.050.

((~~(15)~~)) (16) "Point of service plan" means a benefit plan offered by the pool under which a covered person may elect to receive covered services from network providers, or nonnetwork providers at a reduced rate of benefits.

((~~(16)~~)) (17) "Pool" means the Washington state health insurance pool as created in RCW 48.41.040.

((~~(17)~~)) (18) "Substantially equivalent health plan" means a "health plan" as defined in subsection ((~~(9)~~)) (10) of this section

which, in the judgment of the board or the administrator, offers persons including dependents or spouses covered or making application to be covered by this pool an overall level of benefits deemed approximately equivalent to the minimum benefits available under this pool.

Sec. 8. RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each amended to read as follows:

In addition to the powers and duties specified in RCW 70.47.040 and 70.47.060, the administrator has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the administrator in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance. Any activities of a health care service contractor pursuant to a contract with the administrator under this section shall be exempt from the provisions and requirements of Title 48 RCW <u>except that persons appointed or authorized to solicit applications for enrollment in the basic health plan shall comply with chapter 48.17 RCW</u>.

Sec. 9. RCW 70.47.130 and 1994 c 309 s 6 are each amended to read as follows:

<u>(1)</u> The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW((~~, except as provided in~~

~~RCW 70.47.070 and that the premium and prepayment tax imposed under RCW 48.14.0201 shall apply to amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan~~)) except:

(a) Benefits as provided in RCW 70.47.070;

(b) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection (1)(b), "solicit" does not include distributing information and applications for the basic health plan and responding to questions; and

(c) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201.

(2) The purpose of the 1994 amendatory language to this section in chapter 309, Laws of 1994 is to clarify the intent of the legislature that premiums paid on behalf of nonsubsidized enrollees in the basic health plan are subject to the premium and prepayment tax. The legislature does not consider this clarifying language to either raise existing taxes nor to impose a tax that did not exist previously.

NEW SECTION. **Sec. 10.** Sections 1 and 2 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 1997."

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By Conference Committee

On page 1, line 1 of the title, after "plan;" strike the remainder of the title and insert "amending RCW 70.47.015, 48.43.025, 48.43.035, 48.41.060, 48.41.030, 70.47.120, and 70.47.130; reenacting and amending RCW 70.47.060; adding a new section to chapter 70.47 RCW; providing an effective date; and declaring an emergency."

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