RCW 43.71.080 Assessment to fund exchange—Generally—Stand-alone dental plans. (1)(a) Beginning January 1, 2015, the exchange may require each issuer writing premiums for qualified health benefit plans or stand-alone pediatric dental plans offered through the exchange to pay an assessment in an amount necessary to fund the operations of the exchange, applicable to operational costs incurred beginning January 1, 2015.

(b) The assessment is an exchange user fee. Assessments of issuers may be made only if the amount of expected premium taxes, as provided under RCW 48.14.0201(5)(b) and 48.14.020(2), and other funds deposited in the health benefit exchange account in the current calendar year (excluding premium taxes on stand-alone family dental plans and the assessment received under subsection (3) of this section applicable to stand-alone family dental plans) are insufficient to fund exchange operations in the following calendar year at the level authorized by the legislature for that purpose in the omnibus appropriations act plus three months of additional operating costs.

(c) A health benefit plan or stand-alone dental plan may identify the amount of the assessment to enrollees, but must not bill the enrollee for the amount of the assessment separately from the premium.

(2) The board, in collaboration with the issuers, the health care authority, and the commissioner, must establish a fair and transparent process for calculating the assessment amount. The process must meet the following requirements:

(a) The assessment only applies to issuers that offer coverage in the exchange and only for those market segments offered and must be based on the number of enrollees in qualified health plans and stand-alone dental plans in the exchange for a calendar year;

(b) The assessment must be established on a flat dollar and cents amount per member per month, and the assessment for stand-alone pediatric dental plans must be proportional to the premiums paid for stand-alone dental plans in the exchange;

(c) Issuers must be notified of the assessment amount by the exchange on a timely basis;

(d) An appropriate assessment reconciliation process must be established by the exchange that is administratively efficient;

(e) Issuers must remit the assessment due to the exchange in quarterly installments after receiving notification from the exchange of the due dates of the quarterly installments;

(f) A procedure must be established to allow issuers subject to assessments under this section to have grievances reviewed by an impartial body and reported to the board; and

(g) A procedure for enforcement must be established if an issuer fails to remit its assessment amount to the exchange within ten business days of the quarterly installment due date.

(3)(a) The exchange may require each issuer writing premiums for stand-alone family dental plans offered through the exchange to pay an assessment in an amount necessary to fund the operational costs of offering family dental plans in the exchange, applicable to operational costs incurred beginning January 1, 2017.

(b) The assessment is an exchange user fee. Assessments of issuers may be made only if the amount of expected premium tax received from stand-alone family dental plans, as provided under RCW 48.14.0201(5)(b) and 48.14.020(2), in the current year is insufficient to fund the operational costs estimated to be attributable to offering such stand-alone family dental plans in the exchange, including an

allocation of costs to proportionately cover overall exchange operational costs, in the following calendar year, plus three months of additional operating costs.

(c) If the exchange is charging an assessment, the exchange shall display the amount of the assessment per member per month for enrollees. A stand-alone family dental plan may identify the amount of the assessment to enrollees, but must not bill the enrollee for the amount of the assessment separately from the premium.

(d) The board, in collaboration with the family dental issuers and the commissioner, must establish a fair and transparent process for calculating the assessment amount, including the allocation of overall exchange operational costs. The process must meet the following requirements:

(i) The assessment only applies to issuers that offer stand-alone family dental plans in the exchange and must be based on the number of enrollees in such plans in the exchange for a calendar year;

(ii) The assessment must be established on a flat dollar and cents amount per member per month;

(iii) The requirements included in subsection (2)(c) through (g) of this section shall apply to the assessment described in this subsection (3).

(e) The board, in collaboration with issuers, shall annually assess the viability of offering stand-alone family dental plans on the exchange.

(4) For purposes of this section:

(a) "Stand-alone family dental plan" means coverage for limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the internal revenue code of 1986 and providing pediatric oral services that qualify as coverage for the minimum essential coverage requirement under applicable federal and state law.

(b) "Stand-alone pediatric dental plan" means coverage only for pediatric oral services that qualify as coverage for the minimum essential coverage requirement under applicable federal and state law.

(5) The exchange shall deposit proceeds from the assessments in the health benefit exchange account under RCW 43.71.060.

(6) The assessment described in this section shall be considered a special purpose obligation or assessment in connection with coverage described in this section for the purpose of funding the operations of the exchange, and may not be applied by issuers to vary premium rates at the plan level.

(7) This section does not prohibit an enrollee of a qualified health plan in the exchange from purchasing a plan that offers dental benefits outside the exchange.

(8) This section does not prohibit an issuer from offering a plan that covers dental benefits that do not meet the requirements of a stand-alone family dental plan outside the exchange.

(9) The exchange shall monitor enrollment and provide periodic reports which must be available on its website.

(10) The board shall offer all qualified health plans through the exchange, and the exchange shall not add criteria for certification of qualified health plans beyond those set out in RCW 43.71.065 without specific statutory direction. Nothing shall be construed to limit duties, obligations, and authority otherwise legislatively delegated or granted to the exchange. [2018 c 44 s 8; 2016 c 133 s 3; 2013 2nd sp.s. c 6 s 3.]