ESHB 1846 - S COMM AMD
By Committee on Health Care

OUT OF ORDER 04/15/2013

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 48.43.715 and 2012 c 87 s 13 are each amended to read as follows:

(1) Consistent with federal law, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the minimum requirements of section 1302.

(3) A health plan required to offer the essential health benefits, other than a health plan offered through the federal basic health program or medicaid, under P.L. 111-148 of 2010, as amended, may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner ((~~must~~)):

(a) Must ensure that the plan covers the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended; ((~~and~~))

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended;

(c) Notwithstanding the foregoing, for benefit years beginning January 1, 2015, and only to the extent permitted by federal law and guidance, must establish by rule the review and approval requirements and procedures for pediatric oral services when offered in stand-alone dental plans in the nongrandfathered individual and small group markets outside of the exchange; and

(d) Unless prohibited by federal law and guidance, must allow health carriers to also offer pediatric oral services within the health benefit plan in the nongrandfathered individual and small group markets outside of the exchange.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs.

Sec. 2. RCW 48.46.243 and 2008 c 217 s 56 are each amended 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:

(a) To emergency care from a provider who is not a participating provider((,));

(b) To out-of-area services;

(c) To the delivery of covered pediatric oral services that are substantially equal to the essential health benefits benchmark plan; or((,))

(d) 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 insurance producer, trustee, or assignee thereof, may maintain an action against an enrolled participant to collect sums owed by the health maintenance organization.

Sec. 3. RCW 48.14.0201 and 2011 c 47 s 8 are each amended to read as follows:

(1) As used in this section, "taxpayer" means a health maintenance organization as defined in RCW 48.46.020, a health care service contractor as defined in RCW 48.44.010, a limited health care service contractor, disability carrier, or health maintenance organization offering pediatric oral health services as an essential health benefit, or a self-funded multiple employer welfare arrangement as defined in RCW 48.125.010.

(2) Each taxpayer must pay a tax on or before the first day of March of each year to the state treasurer through the insurance

commissioner's office. The tax must be equal to the total amount of all premiums and prepayments for health care services collected or received by the taxpayer under RCW 48.14.090 during the preceding calendar year multiplied by the rate of two percent. For tax purposes, the reporting of premiums and prepayments must be on a written basis or on a paid-for basis consistent with the basis required by the annual statement.

(3) Taxpayers must prepay their tax obligations under this section. The minimum amount of the prepayments is the percentages of the taxpayer's tax obligation for the preceding calendar year recomputed using the rate in effect for the current year. For the prepayment of taxes due during the first calendar year, the minimum amount of the prepayments is the percentages of the taxpayer's tax obligation that would have been due had the tax been in effect during the previous calendar year. The tax prepayments must be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

(a) On or before June 15, forty-five percent;

(b) On or before September 15, twenty-five percent;

(c) On or before December 15, twenty-five percent.

(4) For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's, health care service contractor's, self-funded multiple employer welfare arrangement's, or certified health plan's prepayment obligations for the current tax year.

(5) Moneys collected under this section are deposited in the general fund.

(6) The taxes imposed in this section do not apply to:

(a) Amounts received by any taxpayer from the United States or any instrumentality thereof as prepayments for health care services provided under Title XVIII (medicare) of the federal social security act.

(b) Amounts received by any taxpayer from the state of Washington as prepayments for health care services provided under:

(i) The medical care services program as provided in RCW 74.09.035; or

(ii) The Washington basic health plan on behalf of subsidized enrollees as provided in chapter 70.47 RCW.

(c) Amounts received by any health care service contractor((,)) as defined in RCW 48.44.010, any limited health care service contractor as defined in RCW 48.44.035, any disability carrier as defined in chapters 48.20 and 48.21 RCW, or any health maintenance organization as defined in chapter 48.46 RCW, as prepayments for health care services included within the definition of practice of dentistry under RCW 18.32.020, except amounts received for pediatric oral services offered as essential health benefits outside of the health benefit exchange under chapter 43.71 RCW.

(d) Participant contributions to self-funded multiple employer welfare arrangements that are not taxable in this state.

(7) Beginning January 1, 2000, the state preempts the field of imposing excise or privilege taxes upon taxpayers and no county, city, town, or other municipal subdivision has the right to impose any such taxes upon such taxpayers. This subsection is limited to premiums and payments for health benefit plans offered by health care service contractors under chapter 48.44 RCW, health maintenance organizations under chapter 48.46 RCW, and self-funded multiple employer welfare arrangements as defined in RCW 48.125.010. The preemption authorized by this subsection must not impair the ability of a county, city, town, or other municipal subdivision to impose excise or privilege taxes upon the health care services directly delivered by the employees of a health maintenance organization under chapter 48.46 RCW.

(8)(a) The taxes imposed by this section apply to a self-funded multiple employer welfare arrangement only in the event that they are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner must initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing state premium taxes on these arrangements. Once the legality of the taxes has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these taxes.

(b) If there has not been a final determination of the legality of these taxes, then beginning on the earlier of (i) the date the fourth multiple employer welfare arrangement has been certified by the

insurance commissioner, or (ii) April 1, 2006, the arrangement must deposit the taxes imposed by this section into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the taxes are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account must be transferred to the state treasurer.

(9) The effect of transferring contracts for health care services from one taxpayer to another taxpayer is to transfer the tax prepayment obligation with respect to the contracts.

(10) On or before June 1st of each year, the commissioner must notify each taxpayer required to make prepayments in that year of the amount of each prepayment and must provide remittance forms to be used by the taxpayer. However, a taxpayer's responsibility to make prepayments is not affected by failure of the commissioner to send, or the taxpayer to receive, the notice or forms."

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On page 1, line 1 of the title, after "coverage;" strike the remainder of the title and insert "and amending RCW 48.43.715, 48.46.243, and 48.14.0201."

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