SHB 2467 - S COMM AMD
By Committee on Health Care

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 43.71.065 and 2012 c 87 s 8 are each amended to read as follows:

(1) The board shall certify a plan as a qualified health plan to be offered through the exchange if the plan is determined by the:

(a) Insurance commissioner to meet the requirements of Title 48 RCW and rules adopted by the commissioner pursuant to chapter 34.05 RCW to implement the requirements of Title 48 RCW;

(b) Board to meet the requirements of the affordable care act for certification as a qualified health plan; and

(c) Board to include tribal clinics and urban Indian clinics as essential community providers in the plan's provider network consistent with federal law. If consistent with federal law, integrated delivery systems shall be exempt from the requirement to include essential community providers in the provider network.

(2)(a) For plan years 2014 and 2015, consistent with section 1311 of P.L. 111-148 of 2010, as amended, the board shall allow stand-alone dental plans to offer coverage in the exchange ((~~beginning January 1, 2014~~)). Dental benefits offered in the exchange must be offered and priced separately to assure transparency for consumers.

(b) For plan years 2016 and higher, consistent with section 1311 of P.L. 111-148 of 2010, as amended, the board shall allow pediatric oral services to be offered in the exchange only through a stand-alone dental plan or a separately rated stand-alone dental plan that is offered in conjunction with an issuer's qualified health plan.

(3) The board may permit direct primary care medical home plans, consistent with section 1301 of P.L. 111-148 of 2010, as amended, to be offered in the exchange beginning January 1, 2014.

(4) Upon request by the board, a state agency shall provide information to the board for its use in determining if the requirements under subsection (1)(b) or (c) of this section have been met. Unless the agency and the board agree to a later date, the agency shall provide the information within sixty days of the request. The exchange shall reimburse the agency for the cost of compiling and providing the requested information within one hundred eighty days of its receipt.

(5) A decision by the board denying a request to certify or recertify a plan as a qualified health plan may be appealed according to procedures adopted by the board."

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On page 1, line 2 of the title, after "exchange;" strike the remainder of the title and insert "and amending RCW 43.71.065."

EFFECT: Specifies the dental benefits are the pediatric oral services required under federal law.

Allows pediatric oral services to be offered through a stand-alone plan or a separately rated stand-alone plan offered in conjunction with the health insurance plan.

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