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**HOUSE BILL 2110**

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**State of Washington 64th Legislature 2015 Regular Session**

**By** Representatives Tharinger and Schmick

AN ACT Relating to taxes and service charges on certain stand-alone dental plans offered through the health benefit exchange; amending RCW 48.14.020 and 48.14.0201; adding a new section to chapter 43.71 RCW; and adding a new section to chapter 82.04 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

**Sec.**  RCW 48.14.020 and 2013 2nd sp.s. c 6 s 6 are each amended to read as follows:

(1) Subject to other provisions of this chapter, each authorized insurer except title insurers ((~~shall~~)) must on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax on premiums. Except as provided in subsection (3) of this section, such tax ((~~shall~~)) must be in the amount of two percent of all premiums, excluding amounts returned to or the amount of reductions in premiums allowed to holders of industrial life policies for payment of premiums directly to an office of the insurer, collected or received by the insurer under RCW 48.14.090 during the preceding calendar year other than ocean marine and foreign trade insurances, after deducting premiums paid to policyholders as returned premiums, upon risks or property resident, situated, or to be performed in this state. For tax purposes, the reporting of premiums ((~~shall~~)) must be on a written basis or on a paid-for basis consistent with the basis required by the annual statement. For the purposes of this section the consideration received by an insurer for the granting of an annuity ((~~shall not be~~)) is not deemed to be a premium.

(2)(a) The taxes imposed in this section do not apply to amounts received by any life and disability insurer for health care services included within the definition of practice of dentistry under RCW 18.32.020 except amounts received for pediatric oral services that qualify as coverage for the minimum essential coverage requirement under P.L. 111-148 (2010), as amended.

(b) Beginning January 1, 2014, moneys collected for premiums written on qualified health benefit plans ((~~and stand-alone dental plans~~)) offered through the health benefit exchange under chapter 43.71 RCW must be deposited in the health benefit exchange account under RCW 43.71.060.

(c) Beginning January 1, 2016, moneys collected for premiums written on stand-alone dental plans for pediatric oral services that qualify as coverage for the minimum essential coverage under P.L. 111-148 (2010), as amended, offered through the health benefit exchange under chapter 43.71 RCW must be deposited in the health benefit exchange account under RCW 43.71.060.

(3) In the case of insurers which require the payment by their policyholders at the inception of their policies of the entire premium thereon in the form of premiums or premium deposits which are the same in amount, based on the character of the risks, regardless of the length of term for which such policies are written, such tax ((~~shall~~)) must be in the amount of two percent of the gross amount of such premiums and premium deposits upon policies on risks resident, located, or to be performed in this state, in force as of the thirty-first day of December next preceding, less the unused or unabsorbed portion of such premiums and premium deposits computed at the average rate thereof actually paid or credited to policyholders or applied in part payment of any renewal premiums or premium deposits on one-year policies expiring during such year.

(4) Each authorized insurer ((~~shall~~)) must with respect to all ocean marine and foreign trade insurance contracts written within this state during the preceding calendar year, on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax of ninety-five one-hundredths of one percent on its gross underwriting profit. Such gross underwriting profit ((~~shall~~)) must be ascertained by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance) on such ocean marine and foreign trade insurance contracts the net losses paid (i.e., gross losses paid less salvage and recoveries on reinsurance ceded) during such calendar year under such contracts. In the case of insurers issuing participating contracts, such gross underwriting profit ((~~shall~~)) does not include, for computation of the tax prescribed by this subsection, the amounts refunded, or paid as participation dividends, by such insurers to the holders of such contracts.

(5) The state does hereby preempt the field of imposing excise or privilege taxes upon insurers or their appointed insurance producers, other than title insurers, and no county, city, town or other municipal subdivision ((~~shall have~~)) has the right to impose any such taxes upon such insurers or these insurance producers.

(6) If an authorized insurer collects or receives any such premiums on account of policies in force in this state which were originally issued by another insurer and which other insurer is not authorized to transact insurance in this state on its own account, such collecting insurer ((~~shall be~~)) is liable for and ((~~shall~~)) must pay the tax on such premiums.

**Sec.**  RCW 48.14.0201 and 2013 2nd sp.s. c 6 s 5 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 chapter 48.44 RCW, 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)(a) Except as provided in (b) and (c) of this subsection, moneys collected under this section are deposited in the general fund.

(b) Beginning January 1, 2014, moneys collected from taxpayers for premiums written on qualified health benefit plans and stand-alone dental plans offered through the health benefit exchange under chapter 43.71 RCW must be deposited in the health benefit exchange account under RCW 43.71.060.

(c) Beginning January 1, 2016, moneys collected for premiums written on stand-alone dental plans for pediatric oral services that qualify as coverage for the minimum essential coverage under P.L. 111-148 (2010), as amended, offered through the health benefit exchange under chapter 43.71 RCW must be deposited in the health benefit exchange account under RCW 43.71.060.

(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 chapter 48.44 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 that qualify as coverage for the minimum essential coverage requirement under P.L. 111-148 (2010), as amended.

(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.

NEW SECTION. **Sec.**  A new section is added to chapter 43.71 RCW to read as follows:

(1)(a) Beginning January 1, 2016, the exchange may require each issuer writing premiums for stand-alone adult and family dental plans offered through the exchange to pay a service charge in an amount necessary to fund the stand-alone adult and family dental operations of the exchange. The service charge may be required only if the expected amount of taxes collected under section 4 of this act and other funds deposited in the health benefit exchange account in the current calendar year are insufficient to fund the stand-alone adult and family dental operational costs incurred beginning January 1, 2016.

(b) The service charge is not an exchange user fee as that term is used in 45 C.F.R. 156.80.

(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 service charge amount. The process must meet the following requirements:

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

(b) The service charge must be established on a flat dollar and cents amount per member per month;

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

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

(e) Issuers must remit the service charge 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 the service charge 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 service charge amount to the exchange within ten business days of the quarterly installment due date.

(3) The exchange must deposit proceeds from the service charges in the health benefit exchange account under RCW 43.71.060.

(4) The service charge described in this section is considered a special purpose obligation 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.

(5) The exchange must monitor stand-alone adult and family dental plan enrollment and provide reports at least annually which must be available on its web site.

(6) For the purposes of this section, "stand-alone adult and family dental plans" means coverage for a set of benefits limited to oral care excluding pediatric oral services that qualify as coverage for the minimum essential coverage under P.L. 111-148 (2010), as amended.

NEW SECTION. **Sec.**  A new section is added to chapter 82.04 RCW to read as follows:

(1) Upon every person engaging within this state in the business of providing stand-alone adult and family dental plans offered through the health benefit exchange under chapter 43.71 RCW; as to such persons the amount of tax is equal to the gross income from such adult and family dental plans multiplied by the rate of 1.5 percent.

(2) The money collected under subsection (1) of this section must be deposited in the health benefit exchange account under RCW 43.71.060.

(3) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Gross income from such adult and family dental plans" does not include premiums received for pediatric oral services that qualify as coverage for the minimum essential coverage under P.L. 111-148 (2010), as amended.

(b) "Stand-alone adult and family dental plans" means coverage for a set of benefits limited to oral care which may or may not include pediatric oral services that qualify as coverage for the minimum essential coverage under P.L. 111-148 (2010), as amended.

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