CERTIFICATION OF ENROLLMENT

HOUSE BILL 2768

Chapter 133, Laws of 2016

64th Legislature
2016 Regular Session

STAND-ALONE DENTAL PLANS--INDIVIDUAL AND SMALL GROUP MARKETS--TAXES AND SERVICE CHARGES

EFFECTIVE DATE: 6/9/2016

Passed by the House February 16, 2016
Yeas 91 Nays 7

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 2, 2016
Yeas 44 Nays 4

BRAD OWEN

President of the Senate

Approved March 31, 2016 4:30 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 2768** as passed by House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

April 1, 2016

Secretary of State
State of Washington

HOUSE BILL 2768

Passed Legislature - 2016 Regular Session

State of Washington 64th Legislature 2016 Regular Session

By Representatives Schmick, Cody, Tharinger, Jinkins, Harris, and Robinson

Read first time 01/20/16. Referred to Committee on Health Care & Wellness.

AN ACT Relating to taxes and service charges on certain qualified stand-alone dental plans offered in the individual or small group markets; and amending RCW 48.14.020, 48.14.0201, and 43.71.080.

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

Sec. 1. 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 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 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 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 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, and for stand-alone family dental plans as defined in RCW 43.71.080(4)(a), only when offered in the individual market, as defined in RCW 48.43.005(27), or to a small group, as defined in RCW 48.43.005(33).

(b) Beginning January 1, 2014, moneys collected for premiums written on qualified health benefit plans and ((~~stand-alone~~)) qualified 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.

(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 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 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 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 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 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 liable for and shall pay the tax on such premiums.

Sec. 2. 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) 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~~)) qualified 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.

(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, and for stand-alone family dental plans as defined in RCW 43.71.080(4)(a), only when offered in the individual market, as defined in RCW 48.43.005(27), or to a small group, as defined in RCW 48.43.005(33).

(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.

Sec. 3. RCW 43.71.080 and 2013 2nd sp.s. c 6 s 3 are each amended to read as follows:

(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 as that term is used in 45 C.F.R. 156.80. 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.

(c) If the exchange is charging an assessment, the exchange shall display the amount of the assessment per member per month for enrollees. 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) Beginning January 1, 2017, 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 as that term is used in 45 C.F.R. Sec. 156.80. 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 P.L. 111-148 (2010), as amended.

(b) "Stand-alone pediatric dental plan" means coverage only for pediatric oral services that qualify as coverage for the minimum essential coverage requirement under P.L. 111-148 (2010), as amended.

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

((~~(4)~~)) (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.

((~~(5)~~)) (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 web site.

((~~(6)~~)) (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.

((~~(7)~~)) (11) The exchange shall report to the joint select committee on health care oversight on a quarterly basis with an update on budget expenses and operations.

((~~(8)~~)) (12) By July 1, 2016, the state auditor shall conduct a performance review of the cost of exchange operations and shall make recommendations to the board and the health care committees of the legislature addressing improvements in cost performance and adoption of best practices. The auditor shall further evaluate the potential cost and customer service benefits through regionalization with other states of some exchange operation functions or through a partnership with the federal government. The cost of the state auditor review must be borne by the exchange.

Passed by the House February 16, 2016.
Passed by the Senate March 2, 2016.
Approved by the Governor March 31, 2016.
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