

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.

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

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

5 **Sec. 1.** RCW 48.14.020 and 2013 2nd sp.s. c 6 s 6 are each
6 amended to read as follows:

7 (1) Subject to other provisions of this chapter, each authorized
8 insurer except title insurers shall on or before the first day of
9 March of each year pay to the state treasurer through the
10 commissioner's office a tax on premiums. Except as provided in
11 subsection (3) of this section, such tax shall be in the amount of
12 two percent of all premiums, excluding amounts returned to or the
13 amount of reductions in premiums allowed to holders of industrial
14 life policies for payment of premiums directly to an office of the
15 insurer, collected or received by the insurer under RCW 48.14.090
16 during the preceding calendar year other than ocean marine and
17 foreign trade insurances, after deducting premiums paid to
18 policyholders as returned premiums, upon risks or property resident,
19 situated, or to be performed in this state. For tax purposes, the
20 reporting of premiums shall be on a written basis or on a paid-for
21 basis consistent with the basis required by the annual statement. For

1 the purposes of this section the consideration received by an insurer
2 for the granting of an annuity shall not be deemed to be a premium.

3 (2)(a) The taxes imposed in this section do not apply to amounts
4 received by any life and disability insurer for health care services
5 included within the definition of practice of dentistry under RCW
6 18.32.020 except amounts received for pediatric oral services that
7 qualify as coverage for the minimum essential coverage requirement
8 under P.L. 111-148 (2010), as amended, and for stand-alone family
9 dental plans as defined in RCW 43.71.080(4)(a), only when offered in
10 the individual market, as defined in RCW 48.43.005(27), or to a small
11 group, as defined in RCW 48.43.005(33).

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

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

30 (4) Each authorized insurer shall with respect to all ocean
31 marine and foreign trade insurance contracts written within this
32 state during the preceding calendar year, on or before the first day
33 of March of each year pay to the state treasurer through the
34 commissioner's office a tax of ninety-five one-hundredths of one
35 percent on its gross underwriting profit. Such gross underwriting
36 profit shall be ascertained by deducting from the net premiums (i.e.,
37 gross premiums less all return premiums and premiums for reinsurance)
38 on such ocean marine and foreign trade insurance contracts the net
39 losses paid (i.e., gross losses paid less salvage and recoveries on
40 reinsurance ceded) during such calendar year under such contracts. In

1 the case of insurers issuing participating contracts, such gross
2 underwriting profit shall not include, for computation of the tax
3 prescribed by this subsection, the amounts refunded, or paid as
4 participation dividends, by such insurers to the holders of such
5 contracts.

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

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

17 **Sec. 2.** RCW 48.14.0201 and 2013 2nd sp.s. c 6 s 5 are each
18 amended to read as follows:

19 (1) As used in this section, "taxpayer" means a health
20 maintenance organization as defined in RCW 48.46.020, a health care
21 service contractor as defined in chapter 48.44 RCW, or a self-funded
22 multiple employer welfare arrangement as defined in RCW 48.125.010.

23 (2) Each taxpayer must pay a tax on or before the first day of
24 March of each year to the state treasurer through the insurance
25 commissioner's office. The tax must be equal to the total amount of
26 all premiums and prepayments for health care services collected or
27 received by the taxpayer under RCW 48.14.090 during the preceding
28 calendar year multiplied by the rate of two percent. For tax
29 purposes, the reporting of premiums and prepayments must be on a
30 written basis or on a paid-for basis consistent with the basis
31 required by the annual statement.

32 (3) Taxpayers must prepay their tax obligations under this
33 section. The minimum amount of the prepayments is the percentages of
34 the taxpayer's tax obligation for the preceding calendar year
35 recomputed using the rate in effect for the current year. For the
36 prepayment of taxes due during the first calendar year, the minimum
37 amount of the prepayments is the percentages of the taxpayer's tax
38 obligation that would have been due had the tax been in effect during
39 the previous calendar year. The tax prepayments must be paid to the

1 state treasurer through the commissioner's office by the due dates
2 and in the following amounts:

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

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

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

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

12 (5)(a) Except as provided in (b) of this subsection, moneys
13 collected under this section are deposited in the general fund.

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

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

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

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

26 (i) The medical care services program as provided in RCW
27 74.09.035; or

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

30 (c) Amounts received by any health care service contractor as
31 defined in chapter 48.44 RCW, or any health maintenance organization
32 as defined in chapter 48.46 RCW, as prepayments for health care
33 services included within the definition of practice of dentistry
34 under RCW 18.32.020, except amounts received for pediatric oral
35 services that qualify as coverage for the minimum essential coverage
36 requirement under P.L. 111-148 (2010), as amended, and for stand-
37 alone family dental plans as defined in RCW 43.71.080(4)(a), only
38 when offered in the individual market, as defined in RCW
39 48.43.005(27), or to a small group, as defined in RCW 48.43.005(33).

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

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

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

26 (b) If there has not been a final determination of the legality
27 of these taxes, then beginning on the earlier of (i) the date the
28 fourth multiple employer welfare arrangement has been certified by
29 the insurance commissioner, or (ii) April 1, 2006, the arrangement
30 must deposit the taxes imposed by this section into an interest
31 bearing escrow account maintained by the arrangement. Upon a final
32 determination that the taxes are not preempted by the employee
33 retirement income security act of 1974, as amended, 29 U.S.C. Sec.
34 1001 et seq., all funds in the interest bearing escrow account must
35 be transferred to the state treasurer.

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

39 (10) On or before June 1st of each year, the commissioner must
40 notify each taxpayer required to make prepayments in that year of the

1 amount of each prepayment and must provide remittance forms to be
2 used by the taxpayer. However, a taxpayer's responsibility to make
3 prepayments is not affected by failure of the commissioner to send,
4 or the taxpayer to receive, the notice or forms.

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

7 (1)(a) Beginning January 1, 2015, the exchange may require each
8 issuer writing premiums for qualified health benefit plans or stand-
9 alone pediatric dental plans offered through the exchange to pay an
10 assessment in an amount necessary to fund the operations of the
11 exchange, applicable to operational costs incurred beginning January
12 1, 2015.

13 (b) The assessment is an exchange user fee as that term is used
14 in 45 C.F.R. 156.80. Assessments of issuers may be made only if the
15 amount of expected premium taxes, as provided under RCW
16 48.14.0201(5)(b) and 48.14.020(2), and other funds deposited in the
17 health benefit exchange account in the current calendar year
18 (excluding premium taxes on stand-alone family dental plans and the
19 assessment received under subsection (3) of this section applicable
20 to stand-alone family dental plans) are insufficient to fund exchange
21 operations in the following calendar year at the level authorized by
22 the legislature for that purpose in the omnibus appropriations act.

23 (c) If the exchange is charging an assessment, the exchange shall
24 display the amount of the assessment per member per month for
25 enrollees. A health benefit plan or stand-alone dental plan may
26 identify the amount of the assessment to enrollees, but must not bill
27 the enrollee for the amount of the assessment separately from the
28 premium.

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

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

37 (b) The assessment must be established on a flat dollar and cents
38 amount per member per month, and the assessment for stand-alone

1 pediatric dental plans must be proportional to the premiums paid for
2 stand-alone dental plans in the exchange;

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

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

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

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

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

16 (3)(a) Beginning January 1, 2017, the exchange may require each
17 issuer writing premiums for stand-alone family dental plans offered
18 through the exchange to pay an assessment in an amount necessary to
19 fund the operational costs of offering family dental plans in the
20 exchange, applicable to operational costs incurred beginning January
21 1, 2017.

22 (b) The assessment is an exchange user fee as that term is used
23 in 45 C.F.R. Sec. 156.80. Assessments of issuers may be made only if
24 the amount of expected premium tax received from stand-alone family
25 dental plans, as provided under RCW 48.14.0201(5)(b) and
26 48.14.020(2), in the current year is insufficient to fund the
27 operational costs estimated to be attributable to offering such
28 stand-alone family dental plans in the exchange, including an
29 allocation of costs to proportionately cover overall exchange
30 operational costs, in the following calendar year, plus three months
31 of additional operating costs.

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

37 (d) The board, in collaboration with the family dental issuers
38 and the commissioner, must establish a fair and transparent process
39 for calculating the assessment amount, including the allocation of

1 overall exchange operational costs. The process must meet the
2 following requirements:

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

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

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

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

14 (4) For purposes of this section:

15 (a) "Stand-alone family dental plan" means coverage for limited
16 scope dental benefits meeting the requirements of section
17 9832(c)(2)(A) of the internal revenue code of 1986 and providing
18 pediatric oral services that qualify as coverage for the minimum
19 essential coverage requirement under P.L. 111-148 (2010), as amended.

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

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

25 ~~((+4))~~ (6) The assessment described in this section shall be
26 considered a special purpose obligation or assessment in connection
27 with coverage described in this section for the purpose of funding
28 the operations of the exchange, and may not be applied by issuers to
29 vary premium rates at the plan level.

30 ~~((+5))~~ (7) This section does not prohibit an enrollee of a
31 qualified health plan in the exchange from purchasing a plan that
32 offers dental benefits outside the exchange.

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

36 (9) The exchange shall monitor enrollment and provide periodic
37 reports which must be available on its web site.

38 ~~((+6))~~ (10) The board shall offer all qualified health plans
39 through the exchange, and the exchange shall not add criteria for
40 certification of qualified health plans beyond those set out in RCW

1 43.71.065 without specific statutory direction. Nothing shall be
2 construed to limit duties, obligations, and authority otherwise
3 legislatively delegated or granted to the exchange.

4 ~~((7))~~ (11) The exchange shall report to the joint select
5 committee on health care oversight on a quarterly basis with an
6 update on budget expenses and operations.

7 ~~((8))~~ (12) By July 1, 2016, the state auditor shall conduct a
8 performance review of the cost of exchange operations and shall make
9 recommendations to the board and the health care committees of the
10 legislature addressing improvements in cost performance and adoption
11 of best practices. The auditor shall further evaluate the potential
12 cost and customer service benefits through regionalization with other
13 states of some exchange operation functions or through a partnership
14 with the federal government. The cost of the state auditor review
15 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.

Filed in Office of Secretary of State April 1, 2016.

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