ESHB 1947 - S AMD **386**
By Senators Becker, Keiser

ADOPTED 06/28/2013

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 43.71.010 and 2012 c 87 s 2 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise. Terms and phrases used in this chapter that are not defined in this section must be defined as consistent with implementation of a state health benefit exchange pursuant to the affordable care act.

(1) "Affordable care act" means the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152, or federal regulations or guidance issued under the affordable care act.

(2) "Authority" means the Washington state health care authority, established under chapter 41.05 RCW.

(3) "Board" means the governing board established in RCW 43.71.020.

(4) "Commissioner" means the insurance commissioner, established in Title 48 RCW.

(5) "Exchange" means the Washington health benefit exchange established in RCW 43.71.020.

(6) "Self-sustaining" means capable of operating ((~~without direct state tax subsidy~~)) with revenue attributable to the operations of the exchange. Self-sustaining sources include, but are not limited to, federal grants, federal premium tax subsidies and credits, charges to health carriers, ((~~and~~)) premiums paid by enrollees, and premium taxes under RCW 48.14.0201(5)(b) and 48.14.020(2).

Sec. 2. RCW 43.71.060 and 2012 c 87 s 5 are each amended to read as follows:

(1) The health benefit exchange account is created in the ((~~custody~~

~~of the state treasurer~~)) state treasury. Moneys in the account may be spent only after appropriation. Expenditures from the account may only be used to fund the operation of the exchange and identification, collection, and distribution of premium taxes collected under RCW 48.14.0201(5)(b) and 48.14.020(2).

(2) The following funds must be deposited in the account:

(a) Premium taxes collected under RCW 48.14.0201(5)(b) and 48.14.020(2);

(b) Assessments authorized under section 3 of this act; and

(c) Amounts transferred by the pool administrator as specified in the state omnibus appropriations act pursuant to RCW 48.41.090.

(3) All receipts from federal grants received under the affordable care act may be deposited into the account. Expenditures from the account may be used only for purposes consistent with the grants((~~. Until March 15, 2012, only the administrator of the health care authority, or his or her designee, may authorize expenditures from the account. Beginning March 15, 2012, only the board of the Washington health benefit exchange or designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.~~

~~(2) This section expires January 1, 2014~~)).

(4) During the 2013-2015 fiscal biennium, the legislature may transfer from the health benefit exchange account to the state general fund such amounts as reflect the excess fund balance of the account.

NEW SECTION. **Sec. 3.** A new section is added to chapter 43.71 RCW 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 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 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 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) The exchange shall deposit proceeds from the assessments in the health benefit exchange account under RCW 43.71.060.

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

(6) 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) 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) 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.

NEW SECTION. **Sec. 4.** A new section is added to chapter 43.135 RCW to read as follows:

RCW 43.135.034(4) does not apply to the dedication of premium taxes established under RCW 48.14.0201(5)(b) or 48.14.020(2).

Sec. 5. RCW 48.14.0201 and 2013 c 325 s 3 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 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.

(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. 6. RCW 48.14.020 and 2013 c 325 s 4 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.

(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.

(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. 7. RCW 48.41.090 and 2005 c 405 s 2 are each amended to read as follows:

(1) Following the close of each accounting year, the pool administrator shall determine the total net cost of pool operation which shall include:

(a) Net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses; and

(b) The amount of pool contributions specified in the state omnibus appropriations act for deposit into the health benefit exchange account under RCW 43.71.060, to assist with the transition of enrollees from the pool into the health benefit exchange created by chapter 43.71 RCW.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction. The numerator of the fraction equals that member's total number of resident insured persons, including spouse and dependents, covered under all health plans in the state by that member during the preceding calendar year. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, covered under all health

plans in the state by all pool members during the preceding calendar year.

(b) For purposes of calculating the numerator and the denominator under (a) of this subsection:

(i) All health plans in the state by the state health care authority include only the uniform medical plan;

(ii) Each ten resident insured persons, including spouse and dependents, under a stop loss plan or the uniform medical plan shall count as one resident insured person;

(iii) Health plans serving medical care services program clients under RCW 74.09.035 are exempted from the calculation; and

(iv) Health plans established to serve elderly clients or ((~~disabled~~)) medicaid clients with disabilities under chapter 74.09 RCW when the plan has been implemented on a demonstration or pilot project basis are exempted from the calculation until July 1, 2009.

(c) Except as provided in RCW 48.41.037, any deficit incurred by the pool, including pool contributions for deposit into the health benefit exchange account, shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members. The monthly per member assessment may not exceed the 2013 assessment level. If the maximum assessment is insufficient to cover a pool deficit the assessment shall be used first to pay all incurred losses and pool administrative expenses, with the remainder being available for deposit in the health benefit exchange account.

(3) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (2) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency.

(4) Subject to the limitation imposed in subsection (2)(c) of this section, the pool administrator shall transfer the assessments for pool contributions for the operation of the health benefit exchange to the treasurer for deposit into the health benefit exchange account with the

quarterly assessments for 2014 as specified in the state omnibus appropriations act. If assessments exceed actual losses and administrative expenses of the pool and pool contributions for deposit into the health benefit exchange account, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

NEW SECTION. **Sec. 8.** A new section is added to chapter 82.04 RCW to read as follows:

(1) The taxes imposed by this chapter do not apply to amounts received by the Washington health benefit exchange established under chapter 43.71 RCW.

(2) This section expires July 1, 2023.

NEW SECTION. **Sec. 9.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 10.** Section 8 of this act applies both prospectively and retroactively."

ESHB 1947 - S AMD
By Senators Becker, Keiser

ADOPTED 06/28/2013

On page 1, line 3 of the title, after "expenses;" strike the remainder of the title and insert "amending RCW 43.71.010, 43.71.060, 48.14.0201, 48.14.020, and 48.41.090; adding a new section to chapter 43.71 RCW; adding a new section to chapter 43.135 RCW; adding a new section to chapter 82.04 RCW; creating a new section; and providing an expiration date."

EFFECT: Modifies references in the exchange treasury account for

deposit of assessments and premium taxes, corrects a reference to the federal grant, and allows the Legislature to transfer excess funds from the account for the 2013-2015 biennium.

Modifies the assessment methodology, removing specific formulas, requiring the Board to establish a fair and transparent process for calculating the assessment amount for the calendar year, in collaboration with insurance carriers, the Health Care Authority, and the Office of Insurance Commissioner.

Includes reference to the dental plan assessment being proportional to the premiums paid for the stand-alone dental plans in the Exchange.

Modifies the premium tax sections to reflect statutory changes passed in the regular session of 2013 (for the dental plans) to ensure the premium tax for Exchange participating plans is deposited into the Exchange account. (Removes deposit of the premium tax from the Medicaid expansion plans to the Exchange account.)

The Exchange must monitor enrollment and post on its web site, and the Exchange must report to the Joint Select Committee on Health Care Oversight on a quarterly basis with an update on budget expenses and operations.

The Board must offer all qualified health plans to consumers and the Exchange must not add criteria for certification of qualified health plans beyond those set in statute without specific statutory direction. Nothing shall be construed to limit the duties, obligations, and authority otherwise legislatively delegated or granted to the Exchange.

Directs WSHIP to continue collecting assessments for the high risk pool in 2014 as well as additional amount directed in the state budget for transfer to the health benefit exchange account, to assist with the transition of enrollees from the high risk pool to the exchange. Provides transitional operational funding while exchange premium tax revenue is collected in 2015. Limits assessment to 2013 level.

Changes "carriers" to "issuers" and inserts references to the stand-alone dental plans.

--- END ---