FINAL BILL REPORT
HB 2768

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Synopsis as Enacted

Brief Description: Addressing taxes and service charges on certain qualified stand-alone dental plans offered in the individual or small group markets.

Sponsors: Representatives Schmick, Cody, Tharinger, Jinkins, Harris and Robinson.

House Committee on Health Care & Wellness
House Committee on Finance
Senate Committee on Health Care
Senate Committee on Ways & Means

Background:

Stand-Alone Pediatric Dental Insurance.
Under the federal Patient Protection and Affordable Care Act (PPACA), every state must establish a health benefit exchange through which consumers may compare and purchase individual and small group health coverage, access premium and cost-sharing subsidies, and apply for Medicaid coverage. If a state does not establish a health benefit exchange, the federal government will operate one for the state. Washington established its health benefit exchange, known as the Washington Healthplanfinder, in 2011 as a public-private partnership. The Washington Healthplanfinder is governed by a board (Board) consisting of members with expertise in the health care system and health care coverage.

The PPACA requires health plans to cover 10 categories of essential health benefits. One of these categories is pediatric oral care. The PPACA allows stand-alone pediatric dental coverage to be offered in the exchange. State law requires the Washington Healthplanfinder to allow stand-alone pediatric dental coverage to be offered. To ensure transparency to consumers, pediatric dental coverage offered in the Washington Healthplanfinder must be offered and priced separately.

The Washington Healthplanfinder is funded through a 2 percent premium tax levied on health plans and stand-alone pediatric dental plans sold through the Washington Healthplanfinder. This tax is in lieu of the business and occupation tax. If these funds are insufficient to cover the expenditure level for the Washington Healthplanfinder as determined by the Legislature, the Washington Healthplanfinder may levy an assessment on the health and pediatric dental plans to make up the difference.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

The Board, in collaboration with the issuers, the Health Care Authority, and the Insurance Commissioner, must establish a fair and transparent process for calculating the assessment amount. The process must:

- apply the assessment only to issuers that offer coverage in the Washington Healthplanfinder and only for those market segments offered;
- base the assessment on the number of enrollees in qualified health plans and stand-alone dental plans in the Washington Healthplanfinder for a calendar year;
- establish the assessment on a flat dollar and cents amount per member per month—the assessment for dental plans must be proportional to the premiums paid for those plans;
- notify issuers of the assessment amount on a timely basis;
- establish an appropriate assessment reconciliation process that is administratively efficient;
- make the assessment due in quarterly installments;
- establish a procedure to allow issuers to have grievances reviewed by an impartial body and reported to the Board; and
- establish a procedure for enforcement of the assessment.

If the Washington Healthplanfinder charges an assessment, it must display the amount of the assessment per member per month for enrollees. A health or pediatric dental plan may identify the amount of the assessment to enrollees, but may not bill the enrollee separately for the assessment.

Summary:

Stand-alone family dental plans offered in the small group or individual market are subject to the 2 percent premium tax. Beginning January 1, 2017, the Washington Healthplanfinder may levy an assessment on issuers writing premiums for stand-alone family dental plans if funds from the premium tax are insufficient to cover the operational costs attributable to offering stand-alone family dental plans in the Washington Healthplanfinder, including an allocation of costs to proportionately cover overall annual exchange operational costs plus three months of additional operating costs.

The Board, in collaboration with the issuers of stand-alone family dental plans and the Insurance Commissioner, must establish a fair and transparent process for calculating the assessment amount. The process must:

- apply the assessment only to issuers that offer stand-alone family dental coverage in the Washington Healthplanfinder;
- base the assessment on the number of enrollees in stand-alone family dental plans offered in the Washington Healthplanfinder for a calendar year;
- establish the assessment on a flat dollar and cents amount per member per month;
- notify issuers of the assessment amount on a timely basis;
- establish an appropriate assessment reconciliation process that is administratively efficient;
- make the assessment due in quarterly installments;
- establish a procedure to allow issuers to have grievances reviewed by an impartial body and reported to the Board; and

- establish a procedure for enforcement of the assessment.

If the Washington Healthplanfinder charges an assessment, it must 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 may not bill the enrollee separately for the assessment.

An enrollee of a health plan purchased through the Washington Healthplanfinder is not prohibited from purchasing a plan offering dental benefits outside of the Washington Healthplanfinder. An issuer is not prohibited from offering a plan that does not meet the requirements of a stand-alone family dental plan outside of the Washington Healthplanfinder.

Votes on Final Passage:

House	91	7
Senate	44	4

Effective: June 9, 2016