SENATE BILL REPORT
HB 2768

As Reported by Senate Committee On:
Health Care, February 25, 2016

Title: An act relating to taxes and service charges on certain qualified stand-alone dental plans offered in the individual or small group markets.

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.

Brief History: Passed House: 2/16/16, 91-7.
Committee Activity: Health Care: 2/23/16, 2/25/16 [DP-WM].

SENATE COMMITTEE ON HEALTH CARE

Majority Report: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Cleveland, Ranking Minority Member; Angel, Bailey, Brown, Conway, Frockt, Jayapal, Keiser, Parlette and Rivers.

Staff: Mich'l Needham (786-7442)

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. Washington established its health benefit exchange (exchange), known as the Washington Healthplanfinder, in 2011 as a public-private partnership.

The health plans available through the exchange must cover 10 categories of essential health benefits. One of these categories is pediatric oral care. Federal law allows stand-alone pediatric dental coverage to be offered in the exchange. State law requires the exchange to allow stand-alone pediatric dental coverage to be offered, and they must be offered and priced separately.

The exchange is funded through a 2 percent premium tax levied on health plans and stand-alone pediatric dental plans sold through the exchange. If these funds are insufficient to cover the expenditure level as determined by the Legislature, the exchange may levy an

---

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.

assessment on the health and pediatric dental plans to make up the difference. The insurance premium tax is a 2 percent tax applied to the gross proceeds of premiums paid for certain forms of insurance, including health care insurance. When applied, this tax is in lieu of the business and occupation (B&O) tax, although issuers do pay B&O tax on income derived from other activities.

The business and occupation (B&O) tax is imposed on the gross receipts of business activities conducted within the state, without any deduction for the cost of doing business. The tax is imposed on the gross receipts from all business activities conducted within the state. Revenues are deposited in the State General Fund. There are several rate categories, and a business may be subject to more than one B&O tax rate, depending on the types of activities conducted. There are multiple exemptions, deductions, and credits to reduce the B&O tax liability for specific taxpayers and business industries. Issuers are subject to a 1.5 percent service and other B&O tax rate, unless they are subject to the insurance premiums tax, in which case the proceeds derived from premiums are exempt from the B&O tax.

Summary of Bill: 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 exchange 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, including an allocation of costs to proportionately cover overall annual exchange operational costs plus three months of additional operating costs.

The exchange 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 exchange;
- base the assessment on the number of enrollees in stand-alone family dental plans offered in the exchange 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 exchange 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 exchange is not prohibited from purchasing a plan offering dental benefits outside of the exchange. 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 exchange.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This just allows stand alone adult dental plans to be offered and to pay the premium tax to fund the Exchange. Currently the Exchange can only offer pediatric dental and our Exchange is the only Exchange in the country not offering adult dental. Before we can offer the adult dental we need to have a financing method to be self-sustaining and this simple mechanism will allow us to offer adult dental.

Persons Testifying: PRO: Representative Schmick, prime sponsor; Pam MacEwan, CEO, Health Benefit Exchange.

Persons Signed In To Testify But Not Testifying: No one.