STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

SENATE BILL 1832 By: Rosino

AS INTRODUCED

An Act relating to dental benefit plans; defining terms; establishing formula for medical loss ratio; requiring annual reporting to the Insurance Department; establishing process for certain data verification; exempting certain dental plans from provisions of act; requiring annual rebate for certain plan years by certain plans; providing for rebate calculation; prohibiting certain rate establishment; directing rule promulgation; establishing provisions for rate determination by Insurance Commissioner; requiring certain rate increase notice; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7140 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this act:

1. "Earned premium" means all monies paid by an enrollee of a dental benefit plan or the dental coverage portion of a health benefit plan as a condition of receiving coverage from the insurer, including any fees or other associated contributions;

2. "Medical loss ratio (MLR)" means the minimum percentage of all premium funds collected by an insurer each year that shall be spent on actual patient care rather than overhead costs; and

3. "Unpaid claim reserves" means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but were not paid within three (3) months of the end of the MLR reporting year.

B. The medical loss ratio for a dental benefit plan or the dental coverage portion of a health benefit plan shall be determined by dividing the numerator by the denominator as prescribed in subsection C of this section.

C. 1. The numerator shall be the amount spent on care. The amount spent on care shall include:

a. the amount expended for clinical dental services which are services within the American Dental Association Code on Dental Procedures and Nomenclature provided to enrollees which includes payments under dental health maintenance organization plans with dental providers whose services are covered by the contract for dental clinical services or supplies covered by the contract; provided, any overpayment that has already been received from providers shall not be reported as a paid claim. Overpayment received by insurers from

providers shall be deducted from incurred claim amounts,

b. unpaid claim reserves, and

c. claim payments recovered by insurers from providers or enrollees using utilization management efforts, provided that payments are deducted from incurred claim amounts.

2. Calculation of the numerator shall not include:

a. administrative costs including, but not limited to, infrastructure, personnel costs, or broker payments,

b. amounts paid to third-party vendors for secondary network savings,

c. amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management, and

d. amounts paid to a provider for professional or administrative services that do not represent compensation or reimbursement for covered services to an enrollee including, but not limited to, dental record copying costs, attorney fees, subrogation vendor fees, and compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to dental personnel, and dental records clerks.

D. The denominator shall include the total amount of the earned premium revenues, excluding federal and state taxes and licensing and regulatory fees paid.

E. On and after the effective date of this act, any dental benefit plan or the dental coverage portion of a health benefit plan that issues, sells, renews, or offers coverage for dental services shall file a medical loss ratio (MLR) with the Insurance Department in the manner and form prescribed by the Department. The MLR reporting year shall be the calendar year during which dental coverage is provided by the plan and shall be submitted not later than July 31 of the calendar year immediately following the reporting year. The report shall be organized by market and product type and, where appropriate, contain the same information required in the 2013 federal Medical Loss Ratio Annual Reporting Form (CMS-10418). All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act, 42 U.S.C., Section 300gg-18, and 45 CFR Part 158.

F. 1. If data verification of the MLR annual report of a dental benefit plan or the dental coverage portion of a health benefit plan is deemed necessary, the Department shall provide the plan with written notification thirty (30) days before the commencement of the financial examination.

2. The dental benefit plan or the dental coverage portion of a health benefit plan shall have thirty (30) days from the date of

notification to submit to the Department all requested data. The Insurance Commissioner may extend the time for a plan to comply with this subsection upon finding of good cause.

G. The Department shall make all data provided to the Department pursuant to this section publicly available.

H. The provisions of this act shall not apply to health benefit plans under Medicaid, the Children's Health Insurance Program, or to the state-sponsored health benefit plans under the insurer known as HealthChoice.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7141 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. On and after the effective date of this act, any dental benefit plan or the dental coverage portion of a health benefit plan that issues, sells, renews, or offers coverage for dental services shall provide an annual rebate to each enrollee of the plan, on a pro rata basis, if the medical loss ratio, excluding federal and state taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than at minimum:

a. eighty percent (80%) for group health plans of a large employer, as defined in 42 U.S.C., Section 18024(b)(1), and

b. seventy-five percent (75%) for plans offered in the individual market or group health plans of small employers, as such terms are defined in 42 U.S.C., Section 18024(b)(2).

2. Dental benefit plans and the dental coverage portion of health benefit plans shall implement the provisions of paragraph 1 of this subsection not later than January 1, 2028.

B. The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the amount by which the percentage described in subsection A of this section exceeds the insurer's reported ratio described in subsections C and D of Section 1 of this act multiplied by the total amount of earned premium revenue, excluding federal and state taxes and licensing or regulatory fees paid, and after taking into account payments or receipts for risk adjustment, risk corridors, and reinsurance.

C. A dental benefit plan or the dental coverage portion of a health benefit plan shall provide any rebate owed to an enrollee no later than August 1 of the calendar year following the reporting year for which the ratio described in subsection A of this section was calculated.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7142 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All carriers offering dental coverage shall file group product base rates and any changes to group rating factors that are to be effective on January 1 of the plan year on or before July 1 of the preceding year.

B. A dental benefit plan or the dental coverage portion of a health benefit plan that issues, sells, renews, or offers coverage for dental services shall not establish rates for any policyholder that are excessive, inadequate, or unfairly discriminatory. The Insurance Commissioner shall promulgate rules to require rate filings and the submission of adequate documentation and supporting information including actuarial opinions or certifications that the rates proposed by dental plans do not result in the medical loss ratio (MLR) exceeding the ratios described in subsection A of Section 2 of this act.

C. 1. If a plan files a base rate change and the administrative expenses, not including taxes and assessments, increase by more than the most recent calendar year's percentage increase in the dental services Consumer Price Index for All Urban Consumers, U.S. city average, not seasonally adjusted, the base rate shall be deemed excessive and presumptively disapproved.

2. If the plan rate is presumptively disapproved:

a. the carrier shall communicate to all employers and individuals covered under a group product that the proposed increase has been presumptively disapproved

and is subject to a hearing by the Insurance Department, and

b. the Department shall conduct a public hearing.

D. The plan shall submit expected rate increases to the Commissioner at least sixty (60) days prior to the proposed implementation of the rates. If the Commissioner does not approve or disapprove the rate filings within a sixty-day period, the carrier may implement and reasonably rely upon the rates. Provided, the Commissioner may require correction of any deficiencies in the rate filing upon later review if the rate the carrier charged is excessive, inadequate, or unfairly discriminatory. A prospective rate adjustment or rebate as described in Section 2 of this act are the sole remedies for rate deficiencies. If the Commissioner finds deficiencies in the rate filing after a sixty-day period, the Commissioner shall provide notice to the carrier, and the carrier shall correct the rate on a prospective basis.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7143 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Beginning July 1, 2025, and on or before July 1 of each year thereafter, each insurer providing dental coverage doing business in this state shall file with the Insurance Department, in the form and manner prescribed by the Department, an annual report on the medical

loss ratio for the preceding calendar year. The medical loss ratio annual report shall include the following:

1. A combined medical loss ratio percentage for all individual dental policies; and

2. A combined medical loss ratio percentage for all group dental policies issued to fully insured groups.

B. Not later than August 1 of each year, the Department shall post the reported medical loss ratio for each dental insurer on a publicly available website in a manner that is easily located and identifiable to the public. The Department may not post the underlying claims, premiums, and other data used to calculate the medical loss ratio and shall treat all claims, premiums, and other data as confidential.

SECTION 5. This act shall become effective November 1, 2024.

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