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Medical Loss Ratios ~~(MLR)~~ for Dental (DLR) Health Care Services Plans Model Act

**Sponsored by Del. Steve Westfall (WV)*

**Co-sponsored by Rep. Rita Mayfield (IL)*

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Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Transparency of Patient Premium Expenditures
Section 5.	<u>Average DLR Identification and Remediation</u> Excess Revenue; Patient Rebate
Section 6.	Rules
Section 7.	Effective Date

Section 1. Title

This Act shall be known and cited as the “[State] Medical Loss Ratios ~~(MLR)~~ for Dental (DLR) Health Care Services Plans Act.”

Section 2. Purpose

The purpose of this Act is to provide for transparency of the expenditure of dental health care plan premiums, and to require annual reports and ~~re~~mediation~~bates to patients~~ if the ~~dental~~medical loss ratio exceeds a certain percentage.

Section 3. Definitions

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Dental carrier" or "carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

(c) "Dental health care service plan" or "plan" means any plan that provides coverage for dental health care services to enrollees in exchange for premiums, and does not include plans under Medicaid or CHIP.

(d) "~~Dental~~Medical loss ratio" or "DMLR" means ~~the minimum~~ percentage of ~~all~~ premium ~~dollars~~funds collected ~~by an insurer for dental insurance plans~~ each year for a dental coverage plan that the dental coverage plan incurs on dental services provided to an enrollee, separate from that must be spent on actual patient care rather than overhead and administrative costs; ~~administration, and other expenses.~~

(i) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

(A) The numerator is the sum of the amount incurred for clinical dental services provided to enrollees, the amount incurred on activities that improve dental care quality, and the amount of claims payments identified through fraud reduction efforts; and

(B) The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures, and any other payments required by federal law.

(1)(a) The Commissioner shall define by rule:

(I) expenditures for clinical dental services;

(II) activities that improve dental care quality;

(III) overhead and administrative cost expenditures; and

(IV) nonprofit community benefit expenditures that are aligned with exclusion parameters and limits outlined in 45 CFR 158.162; except that the commissioner shall ensure that only expenditures

that improve access to dental services or enhance dental health, and no overhead or administrative costs, are reported under this section.

(ii) The definitions promulgated by rule pursuant to this Section must be consistent with similar definitions that are used for the reporting of medical loss ratios by carriers offering health benefit plans in the state. Overhead and administrative costs must not be included in the numerator.

Section 4. Transparency of Patient Premium Expenditures

(a) A carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a DentalMedical Loss Ratio (DMLR) annual report with the Cecommissioner that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The filing must also report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

(b) The DMLR reporting year shall be for the fiscal year during which dental coverage is provided by the plan. All terms used in the DMLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If data verification of the carrier's representations in the DMLR annual report is deemed necessary, the commissioner shall provide the carrier with a notification 30 days to submit any information required by the Commissioner before the commencement of the financial examination.

(d) By January 1 of the year after the Commissioner receives the dental loss ratio information collected pursuant to subsection (a) of this Section, the Commissioner shall make the information, including the aggregate dental loss ratio and other data reported pursuant to this Section, available to the public in a searchable format on a public website that allows members of the public to compare dental loss ratios among carriers by plan type by:

(i) Posting the information on the division's website; or

(ii) Providing the information to the administrator of an all-payer health claims database. If the Commissioner provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the Commissioner. The carrier shall have 30 days from the date of notification to submit to the commissioner all requested data. The commissioner may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

~~(e) The Commissioner shall report the data in this Section, and, if available, Section 5, to the Legislature. The commissioner shall make available to the public all data provided to the commissioner pursuant to this section.~~

**Section 5. Average Loss Ratio Identification and Outlier Remediation~~Excess Revenue;~~
~~Patient Rebate~~**

~~(a) Once the Commissioner has collected the data pursuant to Section 4 for two calendar years, the Commissioner shall promulgate rules that create a process to identify any carriers that significantly deviate from average dental loss ratios and to investigate the causes of the deviation. Such process shall include:~~

~~(i) Calculating an average dental loss ratio for each market segment using aggregate data for a three-year period, consisting of data for the dental loss ratio reporting year that is being reported and the data for the two prior dental loss ratio reporting years;~~

~~(ii) Identifying as outliers the dental coverage plans that fall outside of a set number of standard deviations from the average dental loss ratio, as determined by rule of the Commissioner based on review of the data and consideration of the impact of nonprofit community benefit expenditures on any outlier calculation.~~

~~(iii) The Commissioner may apply more restrictive standard deviation metrics over time to prevent declines in the average dental loss ratio in a market segment and may establish by rule additional criteria for use in identifying outliers.~~

~~A carrier that issues, sells, renews, or offers a plan shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the carrier on the costs for reimbursement for services provided to enrollees under that coverage and for activities that improve dental care quality to the total amount of premium revenue, 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 85%***.~~

~~***Drafting Note: States may wish to consider a different percentage in order to account for varying state economic realities.***~~

~~(b) The Commissioner may enforce compliance with the reporting requirements in this Section and impose a penalty or remedy against a person who violates this Section. 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 subsection (a) of this section multiplied by the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.~~

(c) The Commissioner may investigate or take enforcement actions against carriers that are determined to be outliers pursuant to this Section and rules adopted pursuant to subsection (a) and impose a penalty or remedy against a person who violates this Section~~A carrier shall provide any rebate owing to an enrollee no later than xxxxx of the fiscal year following the year for which the ratio described in subsection (a) of this section was calculated.~~

Section 6. Rules

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act.

Section 7. Effective Date

This Act shall take effect xxxxxxx.