By: Representative Yancey

To: Insurance

HOUSE BILL NO. 1160

AN ACT TO CREATE THE TRANSPARENCY AND ACCOUNTABILITY OF PATIENT PREMIUMS INVESTED IN DENTAL CARE ACT; TO DEFINE "MEDICAL LOSS RATIO" AS THE MINIMUM PERCENTAGE OF ALL PREMIUM FUNDS COLLECTED BY A DENTAL INSURANCE PLAN EACH YEAR THAT MUST BE SPENT ON ACTUAL PATIENT CARE RATHER THAN ADMINISTRATIVE AND OVERHEAD COSTS; TO DEFINE "ADMINISTRATIVE AND OVERHEAD COSTS"; TO PROVIDE THAT A HEALTH CARE SERVICE PLAN THAT ISSUES, SELLS, RENEWS OR OFFERS A SPECIALIZED HEALTH CARE SERVICE PLAN CONTRACT COVERING DENTAL SERVICES SHALL FILE A DENTAL LOSS RATIO WITH THE DEPARTMENT OF INSURANCE THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE AND CONTAINS THE INFORMATION ESTABLISHED IN THE PROVISIONS OF THIS ACT; TO PROVIDE THE TIMELINE FOR SUBMITTING INFORMATION FOR DATA VERIFICATION OF THE HEALTH CARE SERVICE PLAN'S REPRESENTATIONS IN THE MEDICAL LOSS RATIO ANNUAL REPORT; TO PROVIDE THAT THE MEDICAL LOSS RATIO FOR DENTAL INSURANCE PLANS SHALL BE 83%; TO PROVIDE THE METHOD FOR CALCULATING THE TOTAL AMOUNT OF AN ANNUAL REBATE REQUIRED; TO PROVIDE THE TIME THAT A CARRIER OFFERING DENTAL BENEFIT PLANS HAS TO FILE GROUP PRODUCT BASE RATES AND ANY CHANGES; TO AUTHORIZE THE DEPARTMENT OF INSURANCE TO DISAPPROVE ANY BASE RATE CHANGES THAT ARE EXCESSIVE, INADEQUATE OR UNREASONABLE IN RELATION TO BENEFITS CHARGED; TO PROVIDE WHEN THE COMMISSIONER OF INSURANCE MAY PRESUMPTIVELY DISAPPROVE AS EXCESSIVE A DENTAL BENEFIT PLAN CARRIER'S RATE; TO PROVIDE THE HEARING PROCESS FOR WHEN A PROPOSED RATE CHANGE HAS BEEN PRESUMPTIVELY DISAPPROVED; TO AUTHORIZE THE DEPARTMENT OF INSURANCE TO PROMULGATE RULES AND REGULATIONS; TO PROVIDE THE APPLICABILITY OF THE ACT; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. This act shall be known and may be cited as the "Transparency and Accountability of Patient Premiums Invested in Dental Care Act".

SECTION 2. For the purposes of this act, the following words and phrases shall have the meanings as defined herein unless the context clearly indicates otherwise:

(a) "Earned premium" means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the insurer, including any fees or other contributions associated with the dental plan.

(b) "Medical loss ratio (MLR)" means the minimum percentage of all premium funds collected by an insurer each year that must be spent on actual patient care rather than overhead costs. This minimum required percentage that dental insurance plans must meet for the portion of patient premiums must dedicated to patient care rather than administrative and overhead costs, or the difference must be refunded to individuals and groups in the form of rebate.

(c) "Administrative and overhead costs" mean costs that are spent on anything other than patient care.

(d) "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.

SECTION 3. **Transparency of Patient Premiums.** (1) A healthcare service plan that issues, sells, renews or offers a specialized health care service plan contract covering dental services shall file a dental loss ration (DLR) with the Department of Insurance that is organized by market and product type and contains information under the following guidelines.

(2) The medical loss ratio for a dental plan or the dental coverage portion of a health benefit plan shall be determined by dividing the numerator by the denominator as defined in this section.

(a) The numerator shall be the amount spent on care. The amount spent on care shall include:

(i) The amount expended for clinical dental services which are services within the code on dental procedures and nomenclature, provided to enrollees which includes payments under capitation contracts 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 recoveries received from providers shall be deducted from incurred claim amounts;

(ii) Unpaid claim reserves; and

(iii) Claim payments recovered by insurers from providers or enrollees using utilization management efforts, deducted from claim amounts.

(b) Calculation of the numerator shall not include:

(i) All administrative costs, including, but not limited to, infrastructure, personnel costs or broker payments;

(ii) Amounts paid to third-party vendors for secondary network savings;

(iii) Amounts paid to third-party vendors for network development, administrative fees, claims processing and utilization management; and

(iv) 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, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to dental personnel and dental record clerks.

(c) The denominator shall include the total amount of the earned premium revenues, excluding federal and state taxes and licensing and regulatory fees paid after accounting for any payments pursuant to federal law.

(2) A dental benefit plan or the dental portion of a health benefit plan that issues, sells, renews or offers a specialized health benefit plan contract covering dental services on or after the effective date of this act shall file a dental loss ratio (DLR) with the Department of Insurance that is organized by market and product type and, where appropriate, contains the same

information required in the 2013 federal Medical Loss Ratio Annual Reporting Form (CMS-10418).

(3) The DLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act, 42 USC, Section 300gg-18, Part 158 of Title 45 of the Code of Federal Regulations.

(4) If data verification of the dental benefit plan or the dental portion of a health benefit plan's representations in the DLR annual report is deemed necessary, the Department of Insurance shall provide the health benefit plan with a notification thirty (30) days before the commencement of the financial examination.

(5) The dental benefit plan or the dental 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 Commissioner of Insurance may extend the time for a health benefit plan to comply with this subsection (5) upon a finding of good cause.

(6) The department shall make available to the public all of the data provided to the department pursuant to this section.

(7) The provisions of this act shall not apply to health benefit plans under Medicaid, the Children's Health Insurance Program or other state sponsored healthcare programs.

SECTION 4. Excess Revenue-Patient Rebate. (1) A dental benefit plan or the dental portion of a health benefit plan that

issues, sells, renews, or offers a specialized health care service plan contract covering dental services on or after the effective date of this act 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 dental benefit plan or the dental portion of a health benefit plan 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, Sections 2 and 3 of this act, is less than, at minimum, eighty-three percent (83%).

(2) 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 (1) of this section exceeds the insurer's reported ratio described in Sections 2 and 3 of this act 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.

(3) A dental benefit plan or the dental 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 year for which

the ratio described in subsection (1) of this section was calculated.

SECTION 5. Rate Review and Approval Requirements. (1) All carriers offering dental benefit plans shall file group product base rates and any changes to group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The Department of Insurance shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The Department of Insurance shall disapprove any change to group rating factors that is discriminatory or not actuarially sound.

(2) A dental benefit plan or the dental portion of a health benefit plan that issues, sells, renews or offers a specialized health benefit plan contract covering dental services shall not establish rates for any dental coverage plan issued to any policyholder that are excessive, inadequate or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, the Commissioner of Insurance shall promulgate rules to require rate filings and shall require 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 DLR exceeding the ratios described Sections 2 and 3 of this act.

(3) If a carrier files a base rate change and the administrative expense loading component, not including taxes and assessments, increases by more than the most recent calendar year's percentage increase in the dental services Consumer Price Index for All Urban Consumers, United States city average, not seasonally adjusted, or a carrier's reported contribution to surplus exceeds one and nine tenths percent (1.9%), or the aggregate DLR for all plans offered by a carrier is less than the applicable percentage set forth in Sections 2 and 3 of this act, then such carrier's rate shall be presumptively disapproved as excessive by the Department of Insurance.

(4) If the carrier's 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 department; and

(b) The department shall conduct a public hearing and shall properly advertise the hearing in compliance with public hearing requirements;

(5) The Attorney General may intervene in a public hearing or other proceeding under this section and may require additional information as the Attorney General considers necessary to ensure compliance with subsection (4).

(6) The carrier shall submit expected rate increases to the Commissioner at least sixty (60) days before the proposed implementation of the rates.

(7) If the Department of Insurance disapproved the rate submitted by a carrier, the department shall notify the carrier in writing no later than forty-five (45) days before the proposed effective date of the carrier's rate. The carrier may submit a request for hearing to the Department of Insurance within ten (10) days of such notice of disapproval. The department must schedule a hearing within fifteen (15) days of receipt. The Department of Insurance shall issue a written decision within thirty (30) days after the conclusion of the hearing. The carrier may not implement the disapproved rates or changes at any time unless the Department of Insurance reverses the disapproval after the hearing or unless a court vacates the decision of the Department of Insurance.

SECTION 6. Annual Filing. (1) Beginning July 1, 2025, and on or before July 1 of each year thereafter, each dental insurer doing business in this state shall file with the Department of Insurance, in the form and manner prescribed by the department, an annual report on the dental loss ratio for the preceding calendar year. The dental loss ratio annual report shall include the following:

(a) A combined dental loss ratio percentage for all individual dental policies; and

(b) A combined dental loss ratio percentage for all group dental policies issued to fully insured groups.

(2) Not later than August 1 of each year, the department shall post the reported dental loss ratios 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 dental loss ratios and shall treat all claims, premiums and other data as confidential.

SECTION 7. This act shall take effect and be in force from and after July 1, 2025.