By: Representative Lamar

To: Insurance

HOUSE BILL NO. 1131

AN ACT TO CREATE THE TRANSPARENCY AND ACCOUNTABILITY OF PATIENT PREMIUMS INVESTED IN DENTAL CARE ACT; 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 MLR WITH THE DEPARTMENT OF INSURANCE THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE AND CONTAINS THE SAME INFORMATION REQUIRED IN THE 2013 FEDERAL MEDICAL LOSS RATIO ANNUAL REPORTING FORM; 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. Definitions. For purposes of this act, "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 administrative and overhead costs. This minimum required percentage that dental insurance plans must meet for the portion of patient premiums must be 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. "Administrative and overhead costs" mean costs that are spent on anything other than patient care.

SECTION 3. Transparency of Patient Premiums. (1) A health care service plan that issues, sells, renews, or offers a specialized health care service plan contract covering dental services shall file a MLR with the Department of Insurance that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio Annual Reporting Form (CMS-10418).

(2) The MLR 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 Sec. 300gg-18),

Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(3) If data verification of the health care service plan's representations in the MLR annual report is deemed necessary, the Department of Insurance shall provide the health care service plan with a notification thirty (30) days before the commencement of the financial examination.

(4) The health care service plan shall have thirty (30) days from the date of notification to submit all requested data to the Department of Insurance. The Commissioner of Insurance may extend the time for a health care service plan to comply with this subsection upon a finding of good cause.

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

(6) The provisions of this section shall not apply to health care service plans for health care services under Medicaid CHIP or other state sponsored health programs.

SECTION 4. Excess Revenue-Patient Rebate. (1) A health care service plan that issues, sells, renews or offers a specialized health care service plan contract covering dental services 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 specialized health care service 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, as reported in subsection (1) of Section 2 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 MLR as described in subsection (1) of Section 2 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 health care service plan shall provide any rebate owing 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) If (a) 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 (U.S. city average, all urban customers, not seasonally adjusted), or (b) a carrier's reported contribution to surplus exceeds one and nine tenths percent (1.9%), or (c) the aggregate MLR for all plans offered by a carrier is less than the applicable percentage set forth in subsection (1) of Section 3 of this act, then such carrier's rate shall be presumptively disapproved as excessive by the Department of Insurance.

(3) If a proposed rate change has been presumptively disapproved, then the following shall occur:

(a) A 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 at the Department of Insurance;

(b) The Department of Insurance shall conduct a public hearing and shall properly advertise the hearing in compliance with any public hearing requirements; and

(c) 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 this subsection.

(4) 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 a hearing or unless a court vacates the Department of Insurance's decision.

SECTION 6. The Department of Insurance shall promulgate rules and regulations as necessary to effect the provisions of this act by October 1, 2024. This act shall apply to all dental insurance plans issued, made effective, delivered or renewed on or after January 1, 2025, and all current dental insurance plans shall comply with the medical loss ratio and other requirements of this act by January 1, 2025.

SECTION 7. This act shall take effect and be in force from and after July 1, 2024.