

1 STATE OF OKLAHOMA

2 1st Session of the 59th Legislature (2023)

3 COMMITTEE SUBSTITUTE

4 FOR

5 HOUSE BILL NO. 1694

6 By: McEntire

7 COMMITTEE SUBSTITUTE

8 An Act relating to dental insurance; providing
9 definition; providing how a medical loss ratio is
10 calculated; requiring certain health care service
11 plans to file a medical loss ratio report; providing
12 exemptions; verifying medical loss ratio annual
13 report; requiring certain health care service plans
14 to provide annual rebates; requiring the Oklahoma
15 Insurance Department to regulate rates; authorizing
16 the Attorney General to intervene; providing for
17 codification; and providing an effective date.

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

19 SECTION 1. NEW LAW A new section of law to be codified
20 in the Oklahoma Statutes as Section 7350 of Title 36, unless there
21 is created a duplication in numbering, reads as follows:

22 A. As used in this act, "medical loss ratio (MLR)" means the
23 minimum percentage of all premium funds collected by an insurer each
24 year that must be spent on actual patient care rather than overhead
25 costs. The minimum required percentage that dental insurance plans
26 must meet for the portion of patient premiums must be dedicated to
27 patient care rather than administrative and overhead costs or the

1 difference must be refunded to individuals and groups in the form of
2 a rebate.

3 Medical loss ratio for a dental plan or dental coverage of a
4 health benefit plan shall be determined by dividing the numerator by
5 the denominator as defined below:

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

8 a. the amount expended for clinical dental services which
9 are services within the code on dental procedures and
10 nomenclature, provided to enrollees which includes
11 payments under capitation contracts with dental
12 providers, whose services are covered by the contract
13 for dental clinical services or supplies covered by
14 the contract,

15 b. unpaid claim reserves means reserves and liabilities
16 established to account for claims that were incurred
17 during the MLR reporting year but were not paid within
18 three (3) months of the end of the MLR reporting year,

19 c. any overpayment that has already been received from
20 providers should not be reported as a paid claim.
21 Overpayment recoveries received from providers must be
22 deducted from incurred claims amounts, and
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1 d. any claim payment recovered by insurers from providers
2 or enrollees using utilization management efforts, but
3 be deducted from incurred claims amounts.

4 2. The calculation of the numerator does not include:

5 a. all administrative costs including, but not limited
6 to, infrastructure, personnel costs, or broker
7 payments,

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

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

13 d. amounts paid to a providers for professional or
14 administrative services that do not represent
15 compensation or reimbursement for covered services
16 provided to an enrollee, including, but not limited
17 to, dental record copying costs, attorney fees,
18 subrogation vendor fees, compensation to
19 paraprofessionals, janitors, quality assurance
20 analysts, administrative supervisors, secretaries to
21 dental personnel, and dental record clerks.

22 3. The denominator is calculated using insurer revenue.

23 a. earned premium means all monies paid by a policyholder
24 or subscriber as a condition of receiving coverage

1 from the issuer, including any fees or other
2 contributions associated with the dental plan, and
3 b. the denominator is the total amount of the earned
4 premium revenues, excluding federal and state taxes
5 and licensing and regulatory fees paid after
6 accounting for any payments pursuant to federal law.

7 B. A dental benefit plan or the dental portion of a health
8 benefit plan that issues, sells, renews, or offers a specialized
9 health benefit plan contract covering dental services shall file a
10 medical loss ratio (MLR) with the Oklahoma Insurance Department that
11 is organized by market and product type and, where appropriate,
12 contains the same information required in the 2013 federal Medical
13 Loss Ratio Annual Reporting Form (CMS-10418).

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

19 D. If data verification of the dental benefit plan or the
20 dental portion of a health benefit plan's representations in the MLR
21 annual report is deemed necessary, the Department shall provide the
22 health benefit plan with a notification thirty (30) days before the
23 commencement of the financial examination.

1 E. The dental benefit plan or the dental portion of a health
2 benefit plan shall have thirty (30) days from the date of
3 notification to submit to the Department all requested data. The
4 Insurance Commissioner may extend the time for a health benefit plan
5 to comply with this subsection upon a finding of good cause.

6 F. The Department shall make available to the public all of the
7 data provided to the Department pursuant to this section.

8 G. Exempt from this act are health benefit plans for health
9 care services under Medicaid, the Children's Health Insurance
10 Program, or other state-sponsored health programs.

11 SECTION 2. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 7351 of Title 36, unless there
13 is created a duplication in numbering, reads as follows:

14 A. A dental benefit plan or the dental portion of a health
15 benefit plan that issues, sells, renews, or offers a specialized
16 health care service plan contract covering dental services shall
17 provide an annual rebate to each enrollee under that coverage, on a
18 pro rata basis, if the ratio of the amount of premium revenue
19 expended by the dental benefit plan or the dental portion of a
20 health benefit plan on the costs for reimbursement for services
21 provided to enrollees under that coverage and for activities that
22 improve dental care quality to the total amount of premium revenue,
23 excluding federal and state taxes and licensing or regulatory fees,
24 and after accounting for payments or receipts for risk adjustment,

1 risk corridors, and reinsurance, as reported in subsection B of
2 Section 1 of this act, is less than, at minimum, eighty percent
3 (80%).

4 B. The total amount of an annual rebate required under this
5 section shall be calculated in an amount equal to the product of the
6 amount by which the percentage described in subsection A of this
7 section exceeds the insurer's reported ratio described in subsection
8 B of Section 1 of this act multiplied by the total amount of premium
9 revenue, excluding federal and state taxes and licensing or
10 regulatory fees and after accounting for payments or receipts for
11 risk adjustment, risk corridors, and reinsurance.

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

16 SECTION 3. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 7352 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. All carriers offering dental benefit plans shall file group
20 product base rates and any changes to group rating factors that are
21 to be effective on January 1 of each year, on or before July 1 of
22 the preceding year. The Oklahoma Insurance Department shall
23 disapprove any proposed changes to base rates that are excessive,
24 inadequate, or unreasonable in relation to the benefits charged.

1 The Department shall disapprove any change to group rating factors
2 that is discriminatory or not actuarially sound.

3 B. The carrier's rate shall be presumptively disapproved by the
4 Department if:

5 1. A carrier files a base rate change and the administrative
6 expense loading component, not including taxes and assessments,
7 increases by more than the most recent calendar year's percentage
8 increase in the dental services Consumer Price Index for All Urban
9 Consumers, U.S. city average, not seasonally adjusted;

10 2. A carrier's reported contribution to surplus exceeds one and
11 nine-tenths percent (1.9%); or

12 3. The aggregate medical loss ratio for all plans offered by a
13 carrier is less than the applicable percentage set forth in
14 subsection A of Section 2 of this act.

15 C. If a proposed rate change has been presumptively
16 disapproved:

17 1. A carrier shall communicate to all employers and individuals
18 covered under a group product that the proposed increase has been
19 presumptively disapproved and is subject to a hearing by the
20 Department;

21 2. The Department shall conduct a public hearing and shall
22 properly advertise the hearing in compliance with public hearing
23 requirements; and

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

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

16 SECTION 4. This act shall become effective November 1, 2023.

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