HB1694 FULLPCS2 Marcus McEntire-TJ
2/24/2023 4:17:29 pm

COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB1694
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Marcus McEntire

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

PROPOSED COMMITTEE
SUBSTITUTE
FOR
HOUSE BILL NO. 1694 By: McEntire

PROPOSED COMMITTEE SUBSTITUTE

An Act relating to dental insurance; providing definition; providing how a medical loss ratio is calculated; requiring certain health care service plans to file a medical loss ratio report; providing exemptions; verifying medical loss ratio annual report; requiring certain health care service plans to provide annual rebates; requiring the Oklahoma Insurance Department to regulate rates; authorizing the Attorney General to intervene; 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 7350 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in 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 overhead costs. The 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 a rebate.

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

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 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,

b. 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,

c. any overpayment that has already been received from providers should not be reported as a paid claim. Overpayment recoveries received from providers must be deducted from incurred claims amounts, and

d. any claim payment recovered by insurers from providers or enrollees using utilization management efforts, but be deducted from incurred claims amounts.

2. The calculation of the numerator does not include:

a. all 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, or

d. amounts paid to a providers for professional or administrative services that do not represent compensation or reimbursement for covered services provided 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.

3. The denominator is calculated using insurer revenue.

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

from the issuer, including any fees or other contributions associated with the dental plan, and

b. the denominator is 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.

B. 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 file a medical loss ratio (MLR) with the Oklahoma Insurance Department 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).

C. 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 U.S.C., Section 300gg-18, Part 158 of Title 45 of the Code of Federal Regulations.

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

E. 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 Insurance Commissioner may extend the time for a health benefit plan to comply with this subsection upon a finding of good cause.

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

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

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

A. 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 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, as reported in subsection B of Section 1 of this act, is less than, at minimum, eighty percent (80%).

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 subsection B of Section 1 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.

C. A dental benefit plan or the dental portion of a health benefit 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 A of this section was calculated.

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

A. 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 Oklahoma Insurance Department shall disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in relation to the benefits charged.

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

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

1. 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, U.S. city average, not seasonally adjusted;

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

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

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

1. 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 by the Department;

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

3. 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.

D. If the Department disapproves the rate submitted by a carrier, the Department shall notify the carrier in writing no later than forty-five (45) days prior to the proposed effective date of the carrier's rate. The carrier may submit a request for hearing to the Department within ten (10) days of such notice of disapproval. The Department must schedule a hearing within fifteen (15) days upon receipt of the request for hearing. The Department 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 reverses the disapproval after a hearing or unless a court vacates the Department's decision.

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

59-1-7721 TJ 02/24/23