COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB2805 ________________________________
Of the printed Bill

Page ________ Section ________ Lines ________________
Of the Engrossed Bill

By deleting the content of the entire measure, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: TJ Marti

Adopted: ______________________________

____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

PROPOSED OVERSIGHT
COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2805 By: Marti

PROPOSED OVERSIGHT COMMITTEE SUBSTITUTE

An Act relating to dental benefit plans; creating the Oklahoma Medical Loss Ratios for Dental (DLR) Health Care Services Plans Act; defining terms; establishing formula for medical loss ratio; requiring annual reporting to the Oklahoma Insurance Department; establishing process for certain data verification; providing for rebate calculation; directing rule promulgation; establishing provisions for rate determination by Commissioner; requiring certain rate increase notice; amending 36 O.S. 2021, Section 7301, which relates to dental plans; modifying definition; 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 7140 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Medical Loss Ratios for Dental (DLR) Health Care Services Plans Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7141 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this act:

1. "Commissioner" means the Insurance Commissioner of this state;

2. "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;

3. "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 Children's Health Insurance Program (CHIP); and

4. "Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated pursuant to subsection B in this section.

B. The dental loss ratio is calculated by dividing the numerator by the denominator, where:

1. 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 other incurred claims as defined at 45 C.F.R., Section 158.140(a); and

1 2. The denominator is the total amount of premium revenue,
2 excluding federal and state taxes, licensing and regulatory fees
3 paid, nonprofit community expenditures as defined at 45 C.F.R.,
4 Section 158.162(c), and any other payments required by federal law.
5 C. The Commissioner shall define by rule:
6 1. Expenditures for clinical dental services;
7 2. Activities that improve dental care quality, activities
8 conducted by an issuer intended to improve dental care quality shall
9 not exceed five percent (5%) of net premium revenue; and
10 3. Overhead and administrative cost expenditures.
11 D. The definitions promulgated by rule pursuant to this section
12 shall be consistent with similar definitions that are used for the
13 reporting of medical loss ratios by carriers offering health benefit
14 plans in this state. Overhead and administrative costs shall not be
15 included in the numerator.
16 SECTION 3. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 7142 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:
19 A. A carrier that issues, sells, renews, or offers a
20 specialized dental health care service plan contract shall file a
21 Dental Loss Ratio (DLR) annual report with the Commissioner that is
22 organized by market and product type and contains the same
23 information required in the 2013 federal Medical Loss Ratio (MLR)
24 Annual Reporting Form (CMS-10418). The filing shall 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 DLR reporting year shall be for the fiscal year during which dental coverage is provided by the plan. All terms used in the DLR 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 (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 DLR annual report is deemed necessary, the Commissioner shall provide the carrier with a notification thirty (30) days to submit any information required by the Commissioner.

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:

1. Posting the information on the division’s website; or

2. 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.

E. The Commissioner shall report the data in this section to the Legislature.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7143 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Commissioner shall aggregate dental loss ratios for each carrier by year pursuant to Section 3 of this act for each market segment in which the carrier operates. The Commissioner shall calculate an average dental loss ratio (DLR) for each market segment using aggregate data for a three-year period including data for the most recent dental loss ratio reporting year and the data for the two (2) prior dental loss ratio reporting years.

Newer experience shall be subject to reporting standards defined in 45 C.F.R., Section 158.121.

B. The Commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection A of this section, identify as outliers dental plans that fall outside one standard deviation of the average dental loss ratio, and report those plans to the Legislature consistent with the manner set forth in subsections D and E of Section 3 of this act.

1 A carrier shall not be considered an outlier if its DLR in a
2 market segment is within three (3) percentage points of the average
3 dental loss ratio. A higher threshold may be set in unique
4 circumstances as determined reasonable by the Commissioner.
5 C. The Commissioner shall investigate those carriers that
6 report a DLR lower than one standard deviation from the mathematical
7 average, and may take remediation or enforcement actions against
8 them, including ordering such carriers to rebate, in a manner
9 consistent with 45 C.F.R., Part 158(B) of the Affordable Care Act
10 all premiums paid above such amounts that would have caused said
11 carrier to have achieved the mathematical average of the data
12 submitted in a given year for a given market segment.
13 D. The report in subsection B of this section shall be
14 organized to show year-over-year changes in a carrier's outlier
15 status relative to meeting the one (1) standard deviation outlier
16 standard at subsection B of this section. If the DLR for a carrier
17 in a market segment does not increase and remains an outlier as
18 defined in subsection B of this section after two (2) consecutive
19 years, barring unique circumstances as determined reasonable by the
20 Commissioner, the carrier shall be subject to a minimum DLR
21 percentage by market segment. The Commissioner shall promulgate
22 rules establishing the DLR percentage based on, at minimum, the
23 average of existing carrier loss ratios by market segment in the
24

state to be effective no sooner than forty-two (42) months after a carrier is determined to be an outlier as defined in this section.

E. A carrier subject to remediation in subsections C and D of this section shall provide any rebate owing to a policyholder no later than March 1 of the fiscal year following the year for which the ratio described in subsection A of this section was calculated. The Commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

F. The Commissioner may promulgate rules that create a process to identify carriers that increase rates in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the United States Bureau of Labor Statistics.

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

SECTION 5. AMENDATORY 36 O.S. 2021, Section 7301, is amended to read as follows:

Section 7301. A. No contract between a dental plan of a health benefit plan and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health benefit plan unless the services are covered services under the applicable subscriber agreement.

B. As used in this section:

1. "Covered services" means services ~~reimbursable~~ reimbursed under the applicable subscriber agreement, ~~subject~~ notwithstanding,

and without regard to the contractual limitations on subscriber benefits ~~as may apply, including, for example, deductibles, waiting period or frequency limitations~~;

2. "Dental plan" means and shall include any policy of insurance which is issued by a health benefit plan which provides for coverage of dental services not in connection with a medical plan; and

3. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title or any dental service corporation authorized pursuant to Section 2671 of this title.

C. A health benefit plan or dental plan shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based on lack of medical necessity. Any such denial shall be based upon a determination by a dentist who holds a nonrestricted license in the United States. Any written communication to a dentist that includes or pertains to a denial of benefits for all or part of a claim on the basis of a lack of medical necessity shall include the identifier and license number together with state of issuance, and a contact telephone number of the licensed dentist making the adverse determination. The dentist who reviewed the claim shall only be contacted at the telephone number provided in the written communication about the denial during business hours.

SECTION 6. This act shall become effective November 1, 2025.

60-1-13010 TJ 03/02/25