

WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

House Bill 5417

By Delegate Westfall, Hott and Riley

[Introduced February 01, 2024; Referred to the
Committee on Banking and Insurance then Health
and Human Resources]

1 A BILL to amend the Code of West Virginia 1931, as amended, by adding thereto six new sections,
 2 designated §33-63-1, §33-63-2, §33-63-3, §33-63-4, §33-63-5, and §33-63-6, all relating
 3 to dental health care service plans; providing for transparency of expenditures of patient
 4 premiums; requiring carriers to file annual reports; requiring annual rebates to patients if
 5 funds spent for patient care are less than a certain percentage of premium funds; and
 6 requiring legislative and emergency rules.

Be it enacted by the Legislature of West Virginia:

ARTICLE 63. MEDICAL LOSS RATIOS FOR DENTAL HEALTH CARE SERVICES

PLANS.

§33-63-1. Title.

1 This article shall be known as the West Virginia Medical Loss Ratio for Dental (DLR) Health
 2 Care Services Plans Act.

§33-63-2. Purpose.

1 The purpose of this act is to provide for transparency of the expenditure of dental health
 2 care plan premiums, and to require annual reports and remediation if the dental loss ratio falls
 3 below a certain percentage.

§33-63-3. Definitions.

1 For purposes of this article:

2 (a) "Commissioner" means the Insurance Commissioner of this state.

3 (b) "Dental carrier" or "carrier" means a dental insurance company, dental service
 4 corporation, dental plan organization authorized to provide dental benefits, or a health benefits
 5 plan that includes coverage for dental services.

6 (c) "Dental health care service plan" or "plan" means any plan that provides coverage for
 7 dental health care services to enrollees in exchange for premiums, and does not include plans
 8 under Medicaid or CHIP.

9 (d) "Dental loss ratio" or "DLR" means the minimum percentage dollars spent on patient
10 care as calculated pursuant to subsection (i) in this section.

11 (1) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

12 (A) The numerator is the sum of the amount incurred for clinical dental services provided to
13 enrollees, the amount incurred on activities that improve dental care quality, and other incurred
14 claims as defined at 45 CFR 158.140(a); and

15 (B) The denominator is the total amount of premium revenue, excluding federal and state
16 taxes, licensing and regulatory fees paid, nonprofit community expenditures as defined at 45 CFR
17 158.162(c), and any other payments required by federal law.

18 (e)(1) The Commissioner shall define by rule:

19 (A) Expenditures for clinical dental services;

20 (B) Activities that improve dental care quality;

21 (C) (i). Activities conducted by an issuer intended to improve dental care quality may not
22 exceed five percent of net premium revenue;

23 (ii) Overhead and administrative cost expenditures; and

24 (iii) The definitions promulgated by rule pursuant to this section shall be consistent with
25 similar definitions that are used for the reporting of medical loss ratios by carriers offering health
26 benefit plans in the state. Overhead and administrative costs may not be included in the
27 numerator.

§33-63-4. Transparency of patient premium expenditures.

1 (a) Any carrier that issues, sells, renews, or offers a specialized dental health care service
2 plan contract shall file a Dental Loss Ratio (DLR) annual report with the commissioner that is
3 organized by market and product type and contains the same information required in the 2013
4 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The filing shall also
5 report additional data that includes the number of enrollees, the plan cost-sharing and deductible
6 amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed

7 the annual coverage limit.

8 (b) The DLR reporting year shall be for the fiscal year during which dental coverage is
9 provided by the plan. All terms used in the DLR annual report shall have the same meaning as
10 used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing
11 with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

12 (c) If data verification of the carrier's representations in the DLR annual report is deemed
13 necessary, the commissioner shall provide the carrier with a notification 30 days to submit any
14 information required by the commissioner.

15 (d) By January 1 of the year after the commissioner receives the dental loss ratio
16 information collected pursuant to subsection (a) of this section, the commissioner shall make the
17 information, including the aggregate dental loss ratio and other data reported pursuant to this
18 section, available to the public in a searchable format on a public website that allows members of
19 the public to compare dental loss ratios among carriers by plan type by:

20 (1) Posting the information on the division's website; or

21 (2) Providing the information to the administrator of an all-payer health claims database. If
22 the Commissioner provides the information to the administrator, the administrator shall make the
23 information available to the public in a format determined by the commissioner.

24 (e) The commissioner shall report the data in this section to the Legislature.

§33-63-5. Excess revenue rebate.

1 (a) The commissioner shall aggregate dental loss ratios for each carrier by year pursuant
2 to Section 4 for each market segment in which the carrier operates. The commissioner shall
3 calculate an average dental loss ratio for each market segment using aggregate data for a 3-year
4 period including data for the most recent dental loss ratio reporting year and the data for the two
5 prior dental loss ratio reporting years.

6 (1) Newer experience shall be subject to reporting standards at 45 CFR 158.121

7 (b) The Commissioner shall calculate an average dental loss ratio for each market

8 segment using the data pursuant to subsection 5(a), identify as outliers dental plans that fall
9 outside 1 standard deviations of the average dental loss ratio, and report those plans to the
10 Legislature consistent with the manner set forth in subsections 4(e) and 4(d) above.

11 (1) A carrier shall not be considered an outlier if its DLR in a market segment is within three
12 percentage points of the average dental loss ratio. A higher threshold may be set in unique
13 circumstances as determined reasonable by the commissioner.

14 (c) The commissioner shall investigate those carriers that report a DLR lower than one
15 standard deviations from the mathematical average, and may take remediation or enforcement
16 actions against them, including ordering such carriers to rebate, in a manner consistent with 45
17 C.F.R. Part 158(B) of the ACA all premiums paid above such amounts that would have caused
18 said carrier to have achieved the mathematical average of the data submitted in a given year for a
19 given market segment.

20 (d) The report in subsection (b) shall be organized to show year-over-year changes in a
21 carrier's outlier status relative to meeting the one standard deviation outlier standard at subsection
22 (b). If the DLR for a carrier in a market segment does not increase and remains an outlier as
23 defined in subsection (b) after two consecutive years, barring unique circumstances as
24 determined reasonable by the commissioner, the carrier shall be subject to a minimum DLR
25 percentage by market segment. The commissioner shall promulgate rules establishing the DLR
26 percentage based on, at minimum, the average of existing carrier loss ratios by market segment in
27 the state to be effective no sooner than 42 months after a carrier is determined to be an outlier as
28 defined in this section.

29 (e) A carrier subject to remediation in subsections (c) and (d) of this section shall provide
30 any rebate owing to a policyholder no later than September 1, 2025, of the fiscal year following the
31 year for which the ratio described in subsection (a) of this section was calculated. The
32 commissioner may establish alternatives to direct rebates to include premium reductions in the
33 following benefit year.

34 (f) The commissioner may promulgate rules that create a process to identify carriers that
35 increase rates in excess of the percentage increase of the latest dental services Consumer Price
36 Index as reported through the U.S. Bureau of Labor Statistics.

§33-63-6. **Rulemaking.**

1 (a) On or before July 28, 2024, the commissioner shall propose rules for Legislative
2 approval in accordance with the provisions of §29A-3-1 et seq. of this code to effectuate the
3 provisions of this article.

4 (b) On or before July 1, 2024, the commissioner shall promulgate emergency rules
5 pursuant to the provisions of §29A-3-15 of this code to effectuate the provisions of this article.

NOTE: The purpose of this bill is to provide for transparency of the expenditure of dental health care plan premiums, and to require annual reports and rebates to patients if the medical loss ratio exceeds a certain percentage.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.