Session of 2024

HOUSE BILL No. 2752

By Committee on Insurance

Requested by Kevin Robertson on behalf of the Kansas Dental Association

2-7

AN ACT concerning health insurance; relating to dental benefit plans and services; establishing the dental ratio act; requiring the calculation of the annual dental loss ratio by each dental benefit plan; requiring each dental benefit plan to file an annual report; rebating certain dollar amounts to insureds or plan administrators when the dental loss ratio percentage does not meet the required loss ratio percentage; authorizing the commissioner to adopt rules and regulations.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) Sections 1 through 6, and amendments thereto, shall be known and may be cited as the dental loss ratio act.

(b) As used in this act:

(1) "Act" means the dental loss ratio act.

(2) "Actual patient care" means the amount that a dental benefit plan expends on clinical dental services.

(3) "Clinical dental services" means services within the code on dental procedures and nomenclature that are provided to insureds. "Clinical dental services" includes payments under capitation contracts with dental providers whose services or supplies are covered by the contract.

(4) "Commissioner" means the commissioner of insurance.

(5) "Dental benefit plan" means the plan or dental portion of a health benefit plan that issues, sells, renews or offers a specialized health benefit plan contract covering dental services.

(6) (A) "Dental loss ratio" means the percentage of premium dollars collected each year for a dental benefit plan that the dental benefit plan incurs on clinical dental services provided to an insured, separate from overhead and administrative costs.

(B) "Dental loss ratio" is determined by dividing the numerator by the denominator, where:

(i) (a) The numerator is the amount spent on actual patient care including the total amount expended by the dental benefit plan for clinical dental services and unpaid claims reserves, less any overpayment recoveries received by providers and any claim payments recovered by utilization management.

(b) The numerator does not include: (1) Administrative costs, including, but not limited to, infrastructure, personnel costs or broker payments; (2) amounts paid to third-party vendors for secondary network savings, network development, administrative fees, claims processing or utilization management; and (3) amounts paid to providers for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an insured, including, but not limited to, dental record copying costs, attorney fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assistance analysts, administrative supervisors, secretaries and dental record clerks.

(ii) (a) The denominator is the total amount of earned premium revenues and is calculated using dental benefit plan revenue.

(b) The denominator does not include: (1) Federal and state taxes; and (2) licensing and regulatory fees paid after accounting for any payments made pursuant to federal law.

(7) "Dental loss ratio percentage" means the dental loss ratio expressed as a percentage of a dental benefit plan.

(8) "Department" means the Kansas insurance department.

(9) "Earned premium revenues" means all moneys paid by an insured as a condition of receiving coverage from the dental benefit plan, including any fees and other contributions associated with such dental benefit plan.

(10) "Required dental loss ratio percentage" means the minimum percentage that a dental loss ratio of a dental benefit plan must meet in order to avoid issuing rebates. The "required dental loss ratio percentage" may be adjusted by the commissioner from time to time.

Sec. 2. (a) Every dental benefit plan shall file a dental loss ratio annual report with the Kansas insurance department. Such report shall be organized by market and product type and, where appropriate, contain the same information required in the 2013 federal medical loss ratio annual reporting form, known as the CMS-10418.

(b) The dental loss ratio annual reporting year shall be for the calendar year during which dental coverage is provided by the dental benefit plan. All terms used in the dental loss ratio annual report shall have the same meaning as used in the federal public health service act, 42 U.S.C. § 300gg-18, part 158 of title 45 of the code of federal regulations.

(c) The dental benefit plan or the dental portion of a health benefit plan shall have 30 days from the date of notification to submit all requested data to the department. The commissioner may extend the time for a dental benefit plan to comply with this subsection upon a finding of good cause.

(d) Data provided to the department pursuant to this section shall be subject to the provisions of the Kansas open records act, K.S.A. 45-215 et

seq., and amendments thereto.

Sec. 3. (a) On and after July 1, 2025, the required dental loss ratio shall be 85%.

(b) If the dental benefits plan dental loss ratio percentage, as calculated pursuant to section 1, and amendments thereto, is less than the required dental loss ratio percentage, the dental benefit plan shall return the dollar amount reflecting the monetary difference between the required dental loss ratio percentage and the dental benefit plan's actual dental loss ratio percentage in the form of a rebate.

(c) Any rebate shall be issued on a pro rata basis to:

(1) Each individual insured who is enrolled in the dental benefit plan; or

(2) (A) the plan administrator of each organization with enrollees in the dental benefit plan; and

(B) if the rebate is returned to the plan administrator, then the entire amount of such rebate shall be used only to defray the premiums of the insureds enrolled in such dental plan for the next plan year.

Sec. 4. (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 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, United States city average, not seasonally adjusted;

(2) a carrier's reported contribution to surplus exceeds 1.9%; or

(3) the aggregate medical loss ratio for all plans offered by a health insurer is less than the required dental loss ratio percent.

(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; and

(2) the department shall conduct a public hearing and shall properly advertise the hearing in compliance with public hearing requirements.

(d) If the department disapproves the proposed rate change submitted by a carrier, the department shall notify the carrier in writing not later than

45 days prior to the proposed effective date of the carrier's rate. The carrier may submit a request for a hearing to the department within 10 days of such notice of disapproval. The department shall schedule a hearing within 15 days upon receipt of the request for hearing. The department shall issue a written decision within 30 days after the conclusion of the hearing. The carrier shall 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.

Sec. 5. The commissioner may adopt such rules and regulations as are necessary to implement and administer this act.

Sec. 6. This act shall not apply to health benefit plans for healthcare services under medicaid, the children's health insurance program or any other state-sponsored health program.

Sec. 7. This act shall take effect and be in force from and after July 1, 2025 and its publication in the statute book.