STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

SENATE BILL 1060 By: Thompson

AS INTRODUCED

An Act relating to dental benefit plans; defining terms; establishing formula for medical loss ratio; requiring annual reporting to the Insurance Department; establishing process for certain data verification; exempting certain dental plans from provisions of act; requiring annual rebate for certain plan years by certain plans; providing for rebate calculation; prohibiting certain rate establishment; directing rule promulgation; establishing provisions for rate determination by Insurance Commissioner; requiring certain rate increase notice; amending 36 O.S. 2021, Section 7301, which relates to dental plan fee regulation; modifying definitions; 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 7011 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this act:

1. "Earned premium" means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the insurer,

including any fees or other contributions associated with the dental plan;

2. "Medical loss ratio" (MLR) means the minimum percentage of all premium funds collected by an insurer each year that shall be spent on actual patient care rather than overhead costs. The funds to be spent on actual patient care under this subsection shall be refunded to individuals and groups in the form of a rebate; and

3. "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.

B. The medical loss ratio for a dental plan or the dental coverage portion of a health benefit plan shall be determined by dividing the numerator by the denominator as defined in this section.

C. 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; provided, any overpayment

that has already been received from providers shall not be reported as a paid claim. Overpayment recoveries received from providers shall be deducted from incurred claim amounts,

b. unpaid claim reserves, and

c. claim payments recovered by insurers from providers or enrollees using utilization management efforts, deducted from claim amounts.

2. Calculation of the numerator shall 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, and

d. amounts paid to a provider for professional or administrative services that do not represent compensation or reimbursement for covered services to an enrollee, including, but not limited to, dental record copying costs, attorney fees, subrogation vendor fees, and compensation to paraprofessionals, janitors, quality assurance analysts, administrative

supervisors, secretaries to dental personnel, and dental record clerks.

D. The denominator shall include 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.

E. 1. 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 on or after the effective date of this act shall file a medical loss ratio (MLR) with the 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).

2. 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, and Part 158 of Title 45 of the Code of Federal Regulations.

F. 1. If data verification of the dental benefit plan's or the dental portion of a health benefit plan's representations in the MLR annual report is deemed necessary, the Department shall notify the benefit plan thirty (30) days before the commencement of the financial examination.

2. 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 period for a health benefit plan to comply with this subsection upon a finding of good cause.

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

H. The provisions of this act shall not apply to health benefit plans under the state Medicaid program or plans offered to the state-sponsored health benefit plans.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7012 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. 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 on or after the effective date of this act 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, subsections C and D Section 1 of this act, is less than, at minimum:

a. eighty percent (80%) for large group plans as defined in 42 U.S.C., Section 18024(b)(1), and

b. seventy-five percent (75%) for individual and small group plans as defined in 42 U.S.C., Section 18024(b)(2).

2. Dental benefit plans shall implement the provisions of paragraph 1 of this subsection not later than January 1, 2028.

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 subsections C and D 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 owed 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 7013 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. On or before July 1 of the preceding year, 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.

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 not establish rates for any dental coverage plan issued to any policyholder that are excessive, inadequate, or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, the Insurance Commissioner shall promulgate rules to require rate filings and shall require the submission of adequate documentation and supporting information, including actuarial opinions or certifications that the rates proposed by dental plans do not result in the MLR exceeding the ratios described in subsection A of Section 2 of this act.

C. 1. If 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, the base rate shall be deemed excessive and presumptively disapproved.

2. If the carrier's base rate is presumptively disapproved:

a. the 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 Insurance Department, and

b. the Department shall conduct a public hearing and shall properly advertise the hearing in compliance with public hearing requirements.

D. The carrier shall submit expected rate increases to the Commissioner at least sixty (60) days prior to the proposed implementation of the rates. If the Commissioner does not approve or disapprove the rate filings within a sixty-day period, the carrier may implement and reasonably rely upon the rates provided. The Commissioner may require correction of any deficiencies in the rate filing upon later review if the rate the carrier charged is excessive, inadequate, or unfairly discriminatory. A prospective rate adjustment or rebate as described in Section 2 of this act is the sole remedy for rate deficiencies. If the Commissioner finds deficiencies in the rate filing after a sixty-day period, the Commissioner shall provide notice to the carrier, and the carrier shall correct the rate on a prospective basis.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7014 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Beginning July 1, 2026, and on or before July 1 of each year thereafter, each dental insurer doing business in this state shall file with the Insurance Department, in the form and manner prescribed by the Department, an annual report on the dental loss ratio for the preceding calendar year. The dental loss ratio annual report shall include the following:

1. A combined dental loss ratio percentage for all individual dental policies; and

2. A combined dental loss ratio percentage for all group dental policies issued to fully insured groups.

B. Not later than August 1 of each year, the Department shall post the reported dental loss ratios for each dental insurer on a publicly available website in a manner that is easily located and identifiable to the public. The Department may not post the underlying claims, premiums, and other data used to calculate the dental loss ratios and shall treat all claims, premiums, and other data as confidential.

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.

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