

# **WEST VIRGINIA LEGISLATURE**

**2023 REGULAR SESSION**

**Committee Substitute**

**for**

**Senate Bill 290**

BY SENATORS TAKUBO, ROBERTS, CLEMENTS, BARRETT,

AND PLYMALE

[Originating in the Committee on Health and Human

Resources; reported on February 8, 2023]



1 A BILL to amend the Code of West Virginia 1931, as amended, by adding thereto a new article,  
2 designated §33-62-1, §33-62-2, §33-62-3, and §33-62-4, all relating to dental health care  
3 service plans; providing for transparency of expenditures of patient premiums; requiring  
4 carriers to file annual reports; requiring annual rebates in the form of premium reductions  
5 if funds spent for patient care is less than a certain percentage of premium funds; and  
6 providing for legislative and emergency rulemaking.

*Be it enacted by the Legislature of West Virginia:*

**ARTICLE 62. MEDICAL LOSS RATIOS FOR DENTAL HEALTH CARE SERVICES**

**PLANS.**

**§33-62-1. 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) "Large group plan" means any group dental health care service plan that provides  
10 coverage for 51 or more enrollees.

11 (e) "Medical loss ratio" or "MLR" means the minimum percentage of all premium funds  
12 collected by an insurer for dental insurance plans each year that must be spent on actual patient  
13 care rather than overhead costs, administration, and other expenses, as compared to the total  
14 revenue collected from that plan's premiums.

15           (f) “Small group plan” means any group dental health care service plan that provides  
16 coverage for between two and 50 enrollees.

**§33-62-2. 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 Medical Loss Ratio (MLR) 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).

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

9           (c) If data verification of the carrier’s representations in the MLR annual report is deemed  
10 necessary, the commissioner shall provide the carrier with a notification 30 days before the  
11 commencement of the financial examination.

12           (d) The carrier shall have 30 days from the date of notification to submit to the  
13 commissioner all requested data. The commissioner may extend the time for a health care service  
14 plan to comply with this subdivision upon a finding of good cause.

15           (e) The commissioner shall make available to the public all data provided to the  
16 commissioner pursuant to this section.

**§33-62-3. Excess revenue; patient rebate; MLRs based on number of enrollees.**

1           (a) A carrier that issues, sells, renews, or offers a plan shall provide an annual rebate to  
2 each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium  
3 revenue expended by the carrier on the costs for reimbursement for services provided to enrollees  
4 under that coverage and for activities that improve dental care quality to the total amount of  
5 premium revenue, excluding federal and state taxes and licensing or regulatory fees, is less than  
6 that plan’s applicable minimum MLR, as defined in §33-62-3(d).

7           (b) The total amount of an annual rebate required under this section shall be calculated in  
8 an amount equal to the product of the amount by which the percentage described in subsection  
9 (a) of this section exceeds the insurer's reported ratio described in subsection (a) of this section  
10 multiplied by the total amount of premium revenue, excluding federal and state taxes and licensing  
11 or regulatory fees.

12           (c) A carrier shall provide any rebate owing to an enrollee in the form of a plan premium  
13 reduction for which the ratio described in subsection (a) of this section was calculated.

14           (d) The minimum MLR for each plan shall be based on a plan's number of enrollees and  
15 shall be as follows:

16           (1) The minimum MLR for any large group plan shall be 75 percent; and

17           (2) The minimum MLR for any individual plan or any small group plan shall be 70 percent.

**§33-62-4. Rulemaking.**

1           (a) The commissioner shall propose rules for legislative approval in accordance with the  
2 provisions of §29A-3-1 et seq. of this code to effectuate the provisions of this article.

3           (b) The commissioner may promulgate emergency rules pursuant to the provisions of  
4 §29A-3-15 of this code to effectuate the provisions of this article.