

# **WEST VIRGINIA LEGISLATURE**

**2023 REGULAR SESSION**

**Introduced**

## **House Bill 2604**

By Delegates Westfall, Heckert and Williams

[Introduced January 17, 2023; Referred to the Committee

on Banking and Insurance then Finance]

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

*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) "Medical loss ratio" or "MLR" means the minimum percentage of all premium funds  
 10 collected by an insurer for dental insurance plans each year that must be spent on actual patient  
 11 care rather than overhead costs, administration, and other expenses.

**§33-62-2. Transparency of patient premium expenditures.**

1 (a) A 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. Sec. 300gg-18), Part 158 (commencing  
8 with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

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.**

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, and after  
6 accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less  
7 than 85%.

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

13 and reinsurance.

14 (c) A carrier shall provide any rebate owing to an enrollee no later than February 1 of the  
15 fiscal year following the year for which the ratio described in subsection (a) of this section was  
16 calculated.

**§33-62-4.** **Rulemaking.**

1 (a) On or before June 28, 2023, 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 May 1, 2023, 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.