WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

Senate Bill 178

BY SENATORS TAKUBO, PHILLIPS, TARR, CHAPMAN,

OLIVERIO, DEEDS, SWOPE, ROBERTS, HAMILTON, HUNT,

CLEMENTS, WOODRUM, STUART, AND JEFFRIES

[Introduced January 10, 2024]

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

Be it enacted by the Legislature of West Virginia:

ARTICLE 63. MEDICAL LOSS RATIOS FOR DENTAL HEALTH CARE SERVICES PLANS.

§33-63-1. 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 <u>under Medicaid or CHIP.</u>
- 9 (d) "Large group plan" means any group dental health care service plan that provides
- 10 <u>coverage for 51 or more enrollees.</u>
- 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.

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

§33-63-2. 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 <u>federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418).</u>
- 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 <u>necessary, the commissioner shall provide the carrier with a notification 30 days before the</u>
- 11 <u>commencement of the financial examination.</u>
- 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 <u>commissioner pursuant to this section.</u>

§33-63-3. Excess revenue; patient rebate; medical loss ratios based on number of enrollees.

(a) A carrier that issues, sells, renews, or offers a plan 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 carrier 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

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5	premium revenue, excluding federal and state taxes and licensing or regulatory fees, is less than
6	that plan's applicable minimum medical loss ratio (MLR), as defined in §33-62-3(d) of this code.
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.
	§33-63-4. 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.