WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 4810

By Delegates Clark, Hornby, Horst, Hite, Browning,

Ellington, Funkhouser, Masters, White, and Rohrbach

[Introduced January 26, 2026; referred to the

Committee on Health and Human Resources then

Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding a new article, designated §33-64-1, §33-64-2, §33-64-3, §33-64-4, §33-64-5, and §33-64-6, relating to dental health care service plans; defining terms; providing for transparency of expenditures of patient premiums; requiring carriers to file annual reports; prohibiting certain restrictions on method of payment to providers; prohibiting certain contracts, clauses or waivers; providing for enforcement by the Insurance Commissioner; authorizing third-party network contracts; 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 rulemaking.

Be it enacted by the Legislature of West Virginia:

ARTICLE 64. MEDICAL LOSS RATIOS FOR DENTAL HEALTH CARE SERVICES PLANS.

§33-64-1. Definitions.

For purposes of this article:

"Commissioner" shall mean the Insurance Commissioner of West Virginia as set forth in §33-2-1 *et seq.* of this code.

"Dental carrier" or "carrier" shall mean a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

"Dental health care service plan" or "plan" shall mean any plan that provides coverage for dental health care services to enrollees in exchange for premiums. A dental health care service plan or plan shall not include plans under Medicaid or CHIP.

"Express Acceptance" shall mean a clear and direct agreement to the term of payment methods, communicated explicitly by the dental place to the dentist, in writing, signifying acceptance of the payment method without any ambiguity or implied actions.

"Material modification" shall include, but is not limited to, changes to the terms or conditions of a contract that alter.

(A) Reimbursement rates paid to dental care providers;

(B) Fee schedules for dental care providers;

(C) Dental benefits or covered procedures under a plan for which a dental care provider is a network provider;

(D) A dental plan's rules, guidelines, policies, or procedures concerning payment for dental services;

(E) The general policies of the dental plan that affect a reimbursement paid to providers; or

(F) The manner by which a dental plan adjudicates and pays a claim for services.

"Medical loss ratio" or "MLR" shall mean the minimum percentage of all premium funds collected by a carrier or insurer for dental insurance plans each year that must be spent on actual patient care rather than overhead costs, administration, charitable care, and other expenses, as compared to the total revenue collected from that plan's premiums.

"Provider" shall mean a dentist licensed to provide dental services in West Virginia as set forth in §30-4-1 *et seq.* of this code.

"Provider network contract" shall mean a contract entered into between a dental care provider and a dental carrier for the provision of services to enrollees in plans offered by the dental carrier.

"Third party" shall mean an entity that enters into a third party network contract with a dental carrier.

"Third party network contract" shall mean a contract entered into between a dental carrier and a third party carrier or insurer to gain access to the dental care services and discounted rates of a dental care provider under the dental carrier's provider network contract with the dental care provider.

§33-64-2. Transparency of patient premium expenditures.

(a) Any carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a medical loss ratio (MLR) annual report with the commissioner that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418).

(b) The MLR annual report shall include the information required by subsection (a) of this section for the most recent three years 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. § 300gg-18) and Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations.

(c) The MLR annual reports shall provide the number of enrollees, the plan cost sharing, deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

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

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

(f) The commissioner shall make available to the public the information, including the aggregate dental loss ratio for a three year period on the division’s website that allows member of the public to compare medical loss ratios among carrier by plan.

§33-64-3. Methods of payment.

(a) No dental carrier shall contain restrictions on methods of payment from the dental carrier or its vendor or the health maintenance organization to the dentist in which the only acceptable payment method is a credit card payment or any other form of payment method that requires fees or similar charges. For purposes of this section, a dental carrier providing an ACH

payment shall comply with federal requirements at 45 CFR 162.925 (a).

(b) A dental carrier or its contracted vendor or health maintenance organization may initiate or change payment methodology to a dentist using electronic funds transfer payments, including virtual credit card payment, if:

(1) The dental carrier notifies the provider if any fees are associated with a particular payment method;

(2) The dental carrier advises the dentist of the available methods of payment and provides clear instructions to the dentist as to how to select an alternative payment method that does not impose fees or similar charges on the provider; and

(3) The provider or a designee of the provider elects, through express acceptance, to accept payment of the claim using the credit card or electronic funds transfer payment method. Violation of express acceptance nullifies any election on claim payment methodology until such time that an express agreement is executed.

(c) A dentist's selected form of claim payment methodology remains effective until such time as the dentist chooses an alternative method of payment or a new contract is executed.

(d) A dental carrier or its contracted vendor or health maintenance organization that initiates or changes payments to a dentist through the Automated Clearing House Network, as codified in 45 CFR Sections 162.1601 and 162.1602, shall now charge a fee solely to transmit the payment to a dentist unless the dentist has consented to the fee. A dentist's agent may charge reasonable fees when transmitting an Automated Clearing House Network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

(e) The provisions of this section shall not be waived by contract, and any contractual clause in conflict with the provisions of this section or that purport to waive any requirements of this section are void.

(f) Violations of this section shall be subject to enforcement by the Insurance

Commissioner pursuant to the provisions of §33-2-1 *et seq.* of this code.

§33-64-4. Authorizing third party network contracts; carrier requirements.

(a) A dental carrier may enter into a third party network contract to provide access to the dental care services and discounted rates of a dental care provider under a provider network contract only if:

(1) The dental care provider in the network chooses to allow the third party to access the dental care provider's services and discounted rates:

(A) At the time the contract is entered into or renewed; and

(B) Whenever there is a material modification to the third party network contract;

(2) The dental carrier allows the dental care provider to contract directly with the third party instead of allowing the third party to access the dental care provider's services and discounted rates; and

(3) The third party network contract obligates the third party to comply with all applicable terms, limitations, and conditions of the provider network contract.

(b) A dental carrier may not cancel or otherwise terminate a network provider's contract with a dental care provider on the grounds that the dental care provider refuses to allow access by a third party to the dental care services and discounted rates of the dental care provider.

(c) A dental carrier that contracts with a third party to provide access to the services and discounted rates of a dental care provider under a provider network contract shall:

(1) At the time a provider network contract is entered into, renewed or extended, give to the provider, in writing or electronically, a list of all third parties known by the dental carrier to which the dental carrier has or will provide access to the dental care services and discounted rates of the provider under the provider network contract;

(2) Maintain an Internet website through which the provider may obtain a list, updated at least every 90 days, of all third parties that have access to the provider's dental care services and discounted rates under the provider network contract;

(3) Require a third party to identify on each remittance or explanation of payment sent to a provider the source of any contractual discount in rates taken by the third party under the provider network contract;

(4) Notify the provider no less than 30 days prior to the effective date of a new third party network contract;

(5) Notify each third party of the termination of the provider network contract no later than 30 days prior to the effective date of the termination; and

(6) Make available to a provider within 30 days of the provider's request a copy of the provider network contract currently in force that was relied upon by the dental carrier in the adjudication of the provider's claim.

(d) The notice required under subdivisions (4) and (5) of subsection (c) of this section may be provided by any reasonable means, including but not limited to written notice, electronic communication, or an update to an electronic database.

(e) Subject to any applicable continuity of care requirements, agreements, or contractual provisions, a third party's right to access a dental care provider's services and discounted rates under a provider network contract shall terminate on the date the provider network contract is terminated.

(f) The requirements of this section may not be waived by agreement. Any contract provision that purports to waive the requirements of this section or that conflicts with the requirements of this section is null and void.

(g) This section shall not apply to:

(1) Provider network contracts granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website;

(2) The state medical assistance program; or

(3) A dental carrier that relies only on employees of the carrier to provide dental care.

§33-64-5. 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 premium revenue, excluding federal and state taxes and licensing or regulatory fees, is less than that plan's applicable minimum medical loss ratio (MLR) established by subsection (d) of this section.

(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 (d) of this section exceeds the carrier's reported ratio described in subsection (a) of this section multiplied by the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees.

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

(d) The minimum MLR for each plan shall be 85 percent.

§33-64-6. Rulemaking.

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

(b) The commissioner may promulgate emergency rules 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 require transparency of dental health care insurance products. The bill requires annual reporting of the medical loss ratio with the Insurance Commissioner. The bill sets forth standards for the methods by which a dental carrier may

pay a dental provider. The bill authorizes third party networks and sets standards for such networks. The bill requires an annual rebate to be paid in the form of a premium reduction when the MLR is not met. The bill provides for rulemaking.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.