AN ACT CREATING THE MONTANA DENTAL INSURANCE TRANSPARENCY AND ACCOUNTABILITY ACT; PROVIDING DEFINITIONS; PROVIDING FOR TRANSPARENCY OF DENTAL INSURANCE PREMIUMS; PROVIDING FOR ~~INSURANCE~~ CERTAIN REBATES ~~TO CONSUMERS IN THE EVENT OF EXCESS REVENUE~~; ESTABLISHING REPORTING REQUIREMENTS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTION 33-18-208, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title -- purpose -- scope -- exceptions. (1) [Sections 1 through 5] may be cited as the "Montana Dental Insurance Transparency and Accountability Act".

(2) The purpose of [sections 1 through 5] is to:

(a) require that dental insurance coverage has a medical loss ratio that is transparent to the public and fair to covered individuals; and

(b) provide for transparency of the expenditure of dental health care plan premiums and to require annual reports and remediation if the dental loss ratio falls below a certain percentage.

(3) The provisions of [sections 1 through 5] apply to all policies and certificates of individual and group dental insurance offered to, renewed for, or issued to Montana residents by a disability insurer offering dental coverage.

(4) [Sections 1 through 5] do not apply to health insurance coverage that has dental benefits imbedded in the plan in addition to other medical benefits and is subject to the minimum medical loss ratio requirements of Public Law 111-148, the Patient Protection and Affordable Care Act.

(5) [Sections 1 through 5] do not apply to dental care services covered under medicaid or the healthy Montana kids plan provided for in Title 53, chapter 4, part 11.

Section 2. Definitions. As used in [sections 1 through 5], the following definitions apply:

(1) (a) "Dental insurer" means an insurance company licensed to do business in the state that offers coverage for dental services, including excepted benefits as defined in 33-22-140.

(b) The term does not include health insurance coverage described in [section 1(4)].

(2) "Dental loss ratio" means the percentage of premium dollars spent on patient care as calculated pursuant to subsection (3)(b)(i).

(3) (a) "Medical loss ratio" is the minimum percentage of all premium funds collected by an insurer each year that must be spent on actual patient care rather than overhead costs. ~~This minimum required percentage that dental insurance plans must meet for the portion of patient premiums must be dedicated to patient care rather than administrative and overhead costs or the difference must be refunded in the form of a rebate.~~

(b) The dental loss ratio is calculated by dividing the numerator by the denominator, in which:

(i) the numerator is the sum of the amount incurred for clinical dental services provided to enrollees, the amount incurred on activities that improve dental care quality, and other incurred claims as defined in 45 CFR 158.140(a); and

(ii) the denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures as defined in 45 CFR 158.162(c), and any other payments required by federal law.

Section 3. Transparency of dental insurance premiums. (1) A dental insurer that issues, sells, or renews a plan, policy, contract, or certificate covering dental services shall file by March 1 of each year with its annual statement a medical dental loss ratio report with the commissioner of securities and insurance that is organized by market and product type and contains similar information required in the 2013 federal medical loss ratio annual reporting form. The filing must also report additional data that includes the number of enrollees, <u>the plan cost-sharing and deductible amounts,</u> the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

(2) (a) The dental loss ratio reporting year must be for the policy year during which dental

coverage is provided by the insurer. All terms used in the dental loss ratio annual report have the same meaning as used in the federal Public Health Service Act, 42 U.S.C. 300gg-18, and 45 CFR, part 158.

(b) If data verification of the dental insurer's representations in the dental loss ratio annual report is considered necessary, the commissioner shall provide the dental insurer with a notification of the additional information needed within 30 days.

(c) The dental insurer has 30 days from the date of notification to submit to the commissioner all requested data. The commissioner may extend the time for a dental insurer to comply with this subsection (2)(c) on a finding of good cause.

(3) By January 1 of the year after the commissioner receives the dental loss ratio information collected pursuant to [sections 1 through 5], the commissioner shall make the information, including the aggregate dental loss ratio and other data reported pursuant to this section, available to the public in a searchable format on a public website that allows members of the public to compare dental loss ratios among insurers by plan type. The commissioner shall accomplish this by~~:~~

~~(a)~~ posting the information on the department's website~~; and~~

~~(b) requiring the insurer to publish their specific information on the dental insurer's website~~.

(4) The commissioner shall report biennially the data in this section to the economic affairs interim committee in accordance with 5-11-210.

Section 4. Excess revenue -- rebate. (1) The commissioner shall aggregate dental loss ratios for each dental insurer by year pursuant to [section 3] for each market segment in which the dental insurer operates. The commissioner shall calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period, including data for the most recent dental loss ratio reporting year and the data for the two prior dental loss ratio reporting years. Newer experience is subject to reporting standards specified in 45 CFR 158.121.

(2) (a) The commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection (1), identify as outliers dental plans that fall outside 1 standard deviation of the average dental loss ratio, and report those plans to the legislature as provided in [section 3(4)].

(b) A dental insurer may not be considered an outlier if its dental loss ratio in a market segment is within 3 percentage points of the average dental loss ratio. A higher threshold may be set in unique

circumstances as determined reasonable by the commissioner.

(3) The commissioner shall investigate dental insurers that report a dental loss ratio lower than 1 standard deviation from the mathematical average and may take remediation or enforcement actions against them, including ordering them to rebate, in a manner consistent with 45 CFR, part 158, subpart B, all premiums paid above the amounts that would have caused the dental insurer to have achieved the mathematical average of the data submitted in a given year for a given market segment.

(4) The report in subsection (2) is organized to show year-over-year changes in a dental insurer's outlier status relative to meeting the 1 standard deviation outlier standard in subsection (2). If the dental loss ratio for a dental insurer in a market segment does not increase and remains an outlier as described in subsection (2) after 2 consecutive years, barring unique circumstances as determined reasonable by the commissioner, the dental insurer is subject to a minimum dental loss ratio percentage by market segment. The commissioner shall promulgate rules establishing the dental loss ratio percentage based on, at minimum, the average of existing dental insurer loss ratios by market segment in the state to be effective no sooner than 42 months after a dental insurer is determined to be an outlier.

(5) A dental insurer subject to remediation in subsections (3) and (4) shall provide any rebate owing to a policyholder no later than August 1 of the fiscal year following the year for which the ratio described in subsection (1) was calculated. The commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

(6) The commissioner may promulgate rules that create a process to identify dental insurers that increase rates in excess of the percentage increase of the latest dental services consumer price index as reported through the bureau of labor statistics of the United States department of labor.

Section 5. Rulemaking. (1) The commissioner of securities and insurance shall adopt rules to implement the provisions of [sections 1 through 5].

(2) (a) The commissioner shall define by rule:

(i) expenditures for clinical dental services;

(ii) activities that improve dental care quality; and

(iii) overhead and administrative cost expenditures.

(b) Activities conducted by an issuer intended to improve dental care quality may not exceed 5% of net premium revenue.

(3) The definitions promulgated by rule pursuant to this section must be consistent with similar definitions that are used for the reporting of medical loss ratios by insurers offering health insurance coverage in the state. Overhead and administrative costs may not be included in the numerator.

Section 6. Section 33-18-208, MCA, is amended to read:

"**33-18-208. Contract to contain agreements -- rebates prohibited -- life, disability, and annuity contracts.** Except as otherwise expressly provided by law and in [section 4], ~~no~~ a person ~~shall~~ may not knowingly:

(1) permit or offer to make or make any contract of life insurance, life annuity, or disability insurance or agreement as to such contract other than as plainly expressed in the contract issued thereon;

(2) pay or allow or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity any rebate of premiums payable on the contract or any special favor or advantage in the dividends or other benefits thereon or any paid employment or contract for services of any kind or any valuable consideration or inducement whatever not specified in the contract;

(3) directly or indirectly give or sell or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith and whether or not to be specified in the policy or contract, any agreement of any form or nature promising returns and profits or any stocks, bonds, or other securities or interest present or contingent therein or as measured thereby of any insurance company or other corporation, association, or partnership or any dividends or profits accrued or to accrue thereon; or

(4) offer, promise, or give anything of value whatsoever not specified in the contract."

Section 7. Codification instruction. [Sections 1 through 5] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 5].

Section 8. Effective date. [This act] is effective June 1, 2025.

Section 9. Applicability. [This act] applies to dental insurance policies, plans, contracts, and certificates issued or renewed on or after January 1, 2026.

- END -

I hereby certify that the within bill,

SB 335, originated in the Senate.

_____

Secretary of the Senate

_____

President of the Senate

Signed this _____day

of_____, 2025.

_____

Speaker of the House

Signed this _____day
of_____, 2025.

SENATE BILL NO. 335

INTRODUCED BY G. HERTZ

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