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Title.03000

Adopted by the Industry, Business and Labor Committee
February 17, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1481

Introduced by

Representatives Kasper, Dockter, Koppelman, Louser, Ostlie, D. Ruby

Senators Bekkedahl, Cleary, Clemens, Hogan, Lee, Paulson

A BILL for an Act to create and enact a new section to chapter 26.1-36.9 of the North Dakota Century Code, relating to dental insurer rate ~~filing~~ requirements; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

Dental insurer ~~rate filing~~rates - Approval.

1. ~~A dental insurer annually shall file proposed plan rates and any changes to group rating factors that will be effective the following January first with the commissioner, as prescribed by the commissioner.~~

~~2. The commissioner shall disapprove a:~~

~~a. Proposed plan rate that is excessive, inadequate, or unreasonable in relation to the benefits; and~~

~~b. Group rating factor that is discriminatory or not actuarially sound.~~

~~3.~~ The commissioner shall deem a proposed plan rate of a dental insurer to be excessive and disapprove the proposed plan rate if the dental insurer files a rate change and the:

a. Administrative expense component, not including taxes and assessments, increases from the previous year's rate filing by more than four percent;

b. Reported contribution to surplus exceeds two percent of total revenue; or

~~b.~~c. Dental loss ratio for the plan is less than ~~eighty-three~~seventy-five percent.

~~4. a. If the commissioner disapproves a proposed plan rate or group rating factor under subsection 2, the commissioner shall provide notice of disapproval to the dental insurer forty-five days before the proposed effective date of the proposed plan rate or group rating factor.~~

~~b. Within ten days of the notice of disapproval being issued, the dental insurer may request the commissioner hold a hearing.~~

~~c. If a dental insurer requests a hearing under this subsection, the commissioner shall hold a hearing within fifteen days of receipt of the request.~~

~~d. The commissioner shall issue a decision within thirty days following the hearing. A dental insurer may not implement the disapproved proposed plan rate or group rating factor unless the commissioner reverses the disapproval decision following the hearing.~~

~~5. a. If the commissioner disapproves a proposed plan rate under subsection 3, the commissioner shall provide notice of disapproval to the dental insurer forty-five days before the proposed effective date of the proposed plan rate and schedule a public hearing.~~

~~b. Upon notice of the public hearing by the commissioner, the dental insurer shall provide notice of the public hearing and the presumptive disapproval of the proposed plan rate to all employers and individuals covered by the plan.~~

~~c. The commissioner shall issue a decision within thirty days following the public hearing. A dental insurer may not implement the disapproved proposed plan rate unless the commissioner reverses the presumptive disapproval decision following the hearing.~~

~~6.~~2. a. If the annual dental loss ratio for a dental benefit plan is less than ~~eighty-three~~seventy-five percent, the dental insurer offering the plan shall refund the excess premium to covered individuals and groups. As used in this section, "dental loss ratio" means the ratio used to determine the minimum percentage of all premium funds collected by a dental insurer each year which must be spent on actual patient care rather than overhead costs. This minimum required percentage that dental benefit 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 as provided in this section.

b. A dental insurer shall provide notice to all individuals and groups that were covered under the plan during the applicable twelve-month period that such individuals and groups are entitled to a refund on the premium, or if the individual or group remains covered by the dental insurer, that the individual or group is eligible for a credit on the premium for the following twelve-month period.

c. The total of all refunds issued under this subsection must equal the amount of the dental insurer's earned premium which exceeds the amount necessary to achieve a dental loss ratio of ~~eighty-three~~seventy-five percent, calculated using data reported by the dental insurer~~.~~.

d. The dental loss ratio is calculated by dividing the numerator by the denominator as ~~prescribed by the commissioner~~follows:

(1) The numerator is the amount spent on care, which must include:

(a) The amount expended for clinical dental services that are services within the code on dental procedures and nomenclature, provided to enrollees which includes payments under capitation contracts with dental providers, whose services are covered by the contract for dental clinical services or supplies covered by the contract;

(b) Unpaid claim reserves; and

(c) Any claim payment recovered by insurers from providers or enrollees using utilization management efforts, which are deducted from incurred claims amounts.

(2) Any overpayment received from a provider may not be reported as a paid claim. Overpayment recoveries received from a provider must be deducted from incurred claims amounts.

(3) The calculation of the numerator does not include:

(a) All administrative costs, including infrastructure, personnel costs, or broker payments;

(b) Amounts paid to third-party vendors for secondary network savings;

(c) Amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management; or

(d) Amounts paid to providers for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, including dental record copying costs, attorney fees, subrogation vendor fees, and compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to dental personnel, and dental record clerks.

(4) (a) The denominator is calculated using insurer revenue.

(b) The earned premium is all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the dental benefit plan.

(c) The denominator is the total amount of the earned premium revenues, excluding federal and state taxes and licensing and regulatory fees paid after accounting for any payments pursuant to federal law.

~~7.~~3. The commissioner may:

a. Authorize a waiver or adjustment of the refund requirements in this section only if it is determined by the commissioner that issuing refunds would result in financial impairment for the dental insurer.

b. Adopt rules to implement and administer this section.

4. This section does not apply to a dental insurer with one thousand enrollees or less cumulative of all plans based on a three-year average.

SECTION 2. EFFECTIVE DATE. This Act becomes effective on January 1, 2027.