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Title.

Prepared by the Legislative Council
staff for Senator Roers
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Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO
FIRST ENGROSSMENT

ENGROSSED 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 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 rates - Approval.

1. ~~The~~Except as provided in subdivision b of subsection 4, 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
   c. Dental loss ratio for the ~~plan~~dental insurer is less than seventy-five percent in the aggregate.
2. By April first of each year, a dental insurer shall file with the commissioner a report showing the dental insurer's aggregate dental loss ratio for each of the prior three years.
3. a. If the annual dental loss ratio for a dental ~~benefit plan~~insurer is less than seventy-five percent in the aggregate, the dental insurer offering the plan shall equitably refund or credit the excess premium to covered individuals and groups in a

method approved by the commissioner. 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~~insurers 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 impacted 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 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 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.

~~3.~~4. 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. Authorize a waiver or adjustment of the requirements of subdivision a or b of subsection 1 for reasons relating to preserving the financial solvency of the dental insurer or for other reasonable cause shown by the dental insurer.

c. Adopt rules to implement and administer this section.

~~4.~~5. 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.