**2025 HOUSE INDUSTRY, BUSINESS AND LABOR**

**HB 1481**

# 2025 HOUSE STANDING COMMITTEE MINUTES

**Industry, Business and Labor Committee**
Room JW327C, State Capitol

HB 1481
2/4/2025

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.

8:35 a.m. Chairman Warrey called the meeting to order.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Member Absent: Representative Christy

**Discussion Topics:**

- Zero mandates
- Incentivize patient care
- Impact on coverage market
- Insurance rate approval
- Insurance market trickle effect

8:35 a.m. Representative Jim Kasper, District 46, Fargo, ND, introduced, testified and submitted testimony #34432

8:39 a.m. William R. Sherwin, Executive Director, ND Dental Association, testified in favor and submitted testimony #34052, # 34053, #34106 and #34213.

9:09 a.m. Alex Young, Legislative Director, American Council of Life Insurers (ACLI), testified in opposition and submitted testimony #34197.

9:19 a.m. Ben Wogsland, President of Government Affairs, Delta Dental, testified and submitted testimony #34205.

9:38 a.m. Owen Urech, Senior Policy Advisor, AHIP (formerly, America's Health Insurance Plans), testified and submitted testimony in opposition #34023.

9:41 a.m. Chrystal Bartuska, Division Director Life & Health, ND Insurance Department, testified as neutral.

**Additional written testimony:**
Kamila Dornfeld, Williston, ND, submitted testimony in favor #34153.
Peter J. Mecham, Owner, Red River Endodontics, submitted testimony in favor #34162.
Walter Samuel, ND Dental Association, submitted testimony in favor #34185.
Tessa J. Lagein, Dentist/Owner, Bridge City Dentistry, submitted testimony in favor #34199.

9:54 a.m. Chairman Warrey closed the meeting.

*Diane Lillis, Committee Clerk*

February 3, 2025

**RE: House Bill 1481 – OPPOSE**

Dear Chairman Warrey,

On behalf of the National Association of Dental Plans (NADP)[1], America's Health Insurance Plans (AHIP)[2], and the American Council of Life Insurers (ACLI)[3], we appreciate the opportunity to provide comments in opposition to House Bill 1481. As introduced, this bill would create a dental minimum loss ratio (MLR) of 83 percent for dental benefit plans. This bill would create unintended consequences that severely impact access to dental care and benefits for North Dakotans. It would lead to increased premiums, reduced use and access to dental services, and a reduction in employer and consumer options for purchasing dental coverage.

**Dental Plans Differ from Medical Plans**

Dental plans offer a wide variety of products and benefit designs compared with medical plans. Any measurement of a dental plan's value must reflect the fundamental differences between how medical and dental plans are structured, priced, offered, and purchased if it is to be accurate and meaningful to consumers.

Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventive services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Consumers share a higher percentage of the cost for restorative procedures such as crowns, periodontal surgery, and dentures. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5 percent.

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[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

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In North Dakota, dental premiums are on average, about $33 per month[4] and medical premiums are, on average, about $708 per month.[5] At an 85 percent loss ratio, this leaves medical plans with over $100 to cover administrative expenses per member per month. At an 83 percent loss ratio, dental plans would be left with less than $6 to cover administrative expenses per member per month. This small amount would not cover the cost of basic plan operations for even the most cost efficient plans: administration; claims systems; compliance; and state-mandated consumer protections and commissions. If low-cost plans cannot cover their administrative expenses under the 83 percent loss ratio, those plans may be forced to no longer offer in North Dakota or to raise premiums to cover increased costs.

In Massachusetts, the only state to adopt a similar, mandatory dental loss ratio (through ballot initiative), the market for dental insurance has contracted significantly, with at least 8 fewer carriers in the small group and individual markets, a 25 percent decline, since the imposition of the DLR in 2022. An independent analysis of similar bills indicates that a mandated dental loss ratio of 85 percent could raise premiums for dental coverage by 114 percent for small groups, and 78 percent for the individual market.[6] The analysis highlighted the risk that such a sudden and rapid increase in the cost of coverage will lead many small businesses to forgo dental plans for their employees and reduce access to oral health care.

**Dental Plans and Oral Health**

House Bill 1481 has the potential to dramatically reduce the availability of dental coverage in North Dakota with negative effects on access to oral health care. Dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Under a typical dental plan, preventive care is covered at 100 percent cost sharing to incentivize utilization and a regular relationship with a dentist. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

Dental insurance has been shown to be highly price sensitive and an increase in premiums may lead to a reduction in dental coverage. Losing coverage often means patients must pay full list price for their dental care and a cleaning may cost hundreds of dollars out of pocket. As a result, many people without dental coverage skip regular preventive services to reduce costs and in the long term this increases their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions. For these reasons, we oppose House Bill 1481 and urge you not to advance the legislation.

Thank you for your consideration. We look forward to working with you to develop alternative avenues to evaluate the value of dental benefits in North Dakota.

Respectfully submitted,

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[4] NADP, 2024. Dental Benefits Report. (link)

[5] "Average Annual Singel Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation (2023). Employers typically contribute about $613 per month while employees typically contribute about $95 per month.

[6] AB 2028 Medical Loss Ratios Report final to Legislature 04122024.pdf

Bianca Balale
Director of Government Relations
National Association of Dental Plans

Owen Urech
Senior Policy Advisor, Product Policy
AHIP

Alex Young
Legislative Director, State Relations
ACLI

North Dakota DENTAL ASSOCIATION

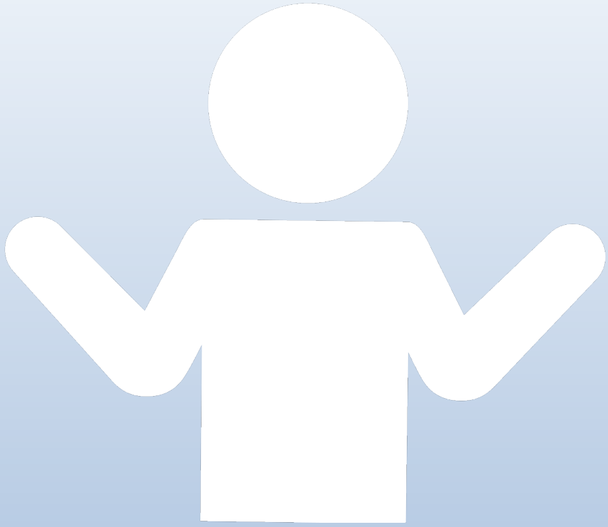
ADA®

# MEDICAL LOSS RATIO FOR DENTAL INSURANCE

WWW.SMILENORTHDAKOTA.ORG
WWW.ADA.ORG

What is Medical Loss Ratio (MLR)?

How does it help patients?



What is the difference between general health insurance and dental insurance?

What progress has been made in the states?

# THE DIFFERENCE BETWEEN GENERAL HEALTH INSURANCE AND DENTAL INSURANCE

General Health Insurance: Provides unexpected/catastrophic coverage

Dental Insurance: Provides only basic preventative care

## GENERAL HEALTH INSURANCE

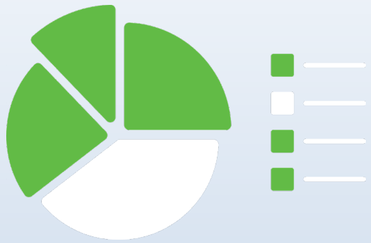
- No annual limit; unused benefits do not roll back into insurers' bank
- Risk-based
- Able to spread risk
- Plan design encourages prevention and catastrophic care costs

## DENTAL INSURANCE

- Limited annual care expenditure
- Insurance payments are generally low (lower premiums)
- Designed to cover basic preventative care rather than treatment of dental disease
- Insurance typically covers 50% of costs for major issues (usually capped at $1,000 per year)
- Tends to be treated as a stipend. Many employers do not cover or offer it at all

# SUMMARY

| Plan Components | Medical | Dental |
|---|---|---|
| Annual Limit on Expenditures | x | ✓ |
| Risk Bearing-Spreading Risk | ✓ | x |
| Preexisting Condition Limits | x | ✓ |
| Must Comply with PPA | ✓ | x |
| Deductibles | ✓ | ✓ |
| Co-Pay/Coinsurance | ✓ | ✓ |
| Prior Authorizations | ✓ | ✓ |



# WHAT IS MEDICAL LOSS RATIO (MLR)?

**The percentage of insurance premiums spent on patient care, rather than on overhead costs, like executive salaries and administration.**

# HB 1481 CONSUMER PROTECTIONS

1

Adds transparency to dental insurance

2

Establishes a minimum percentage of premiums that dental insurers must spend on patient care

3

Requires carriers who do not meet the minimum percentage to refund the difference to covered patients and groups

# HOW THIS BILL HELPS PATIENTS

Improves the value employers and patients get for their premium dollars

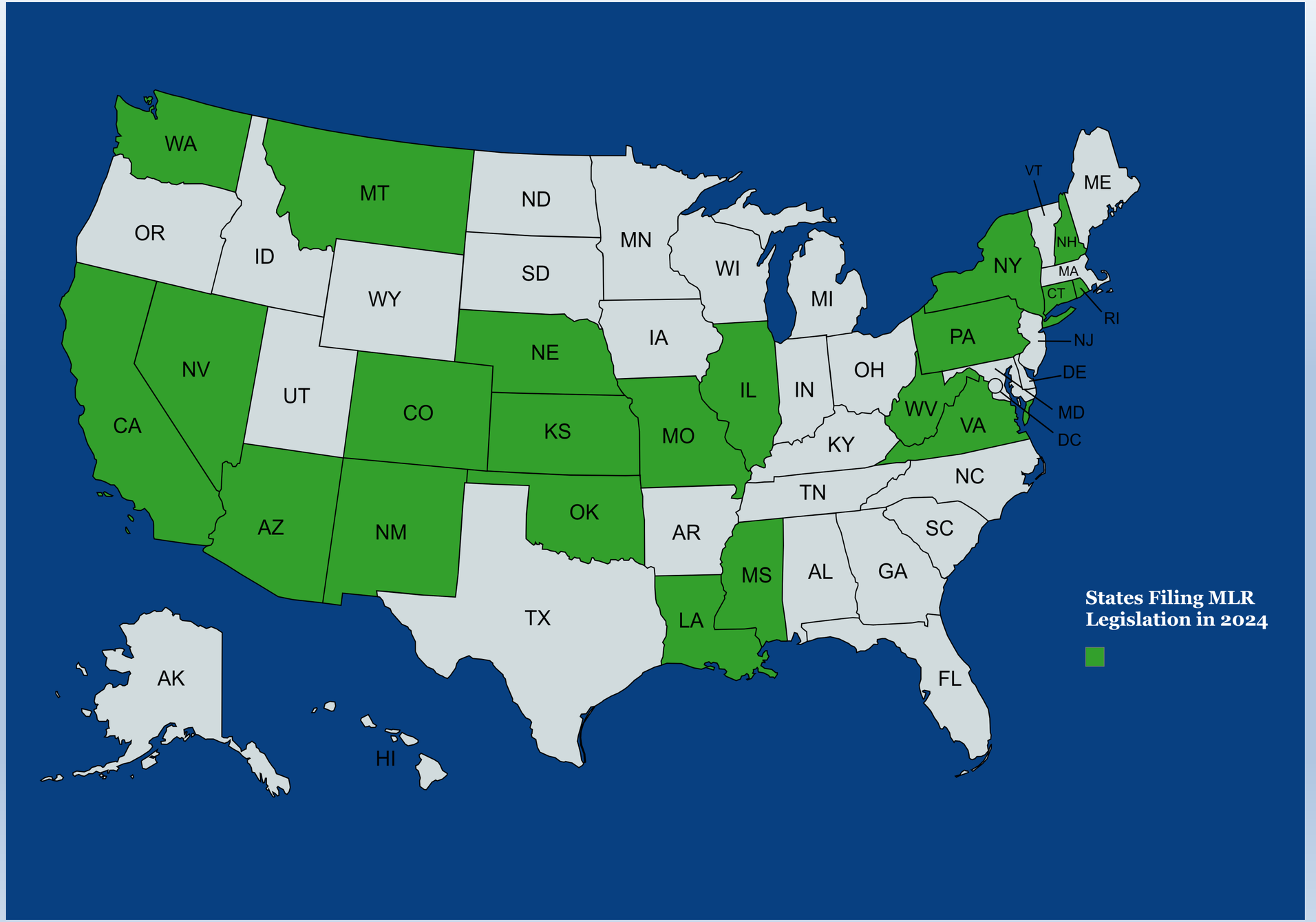
Makes dental insurance more reliable

Patients will get the care they need, when they need it

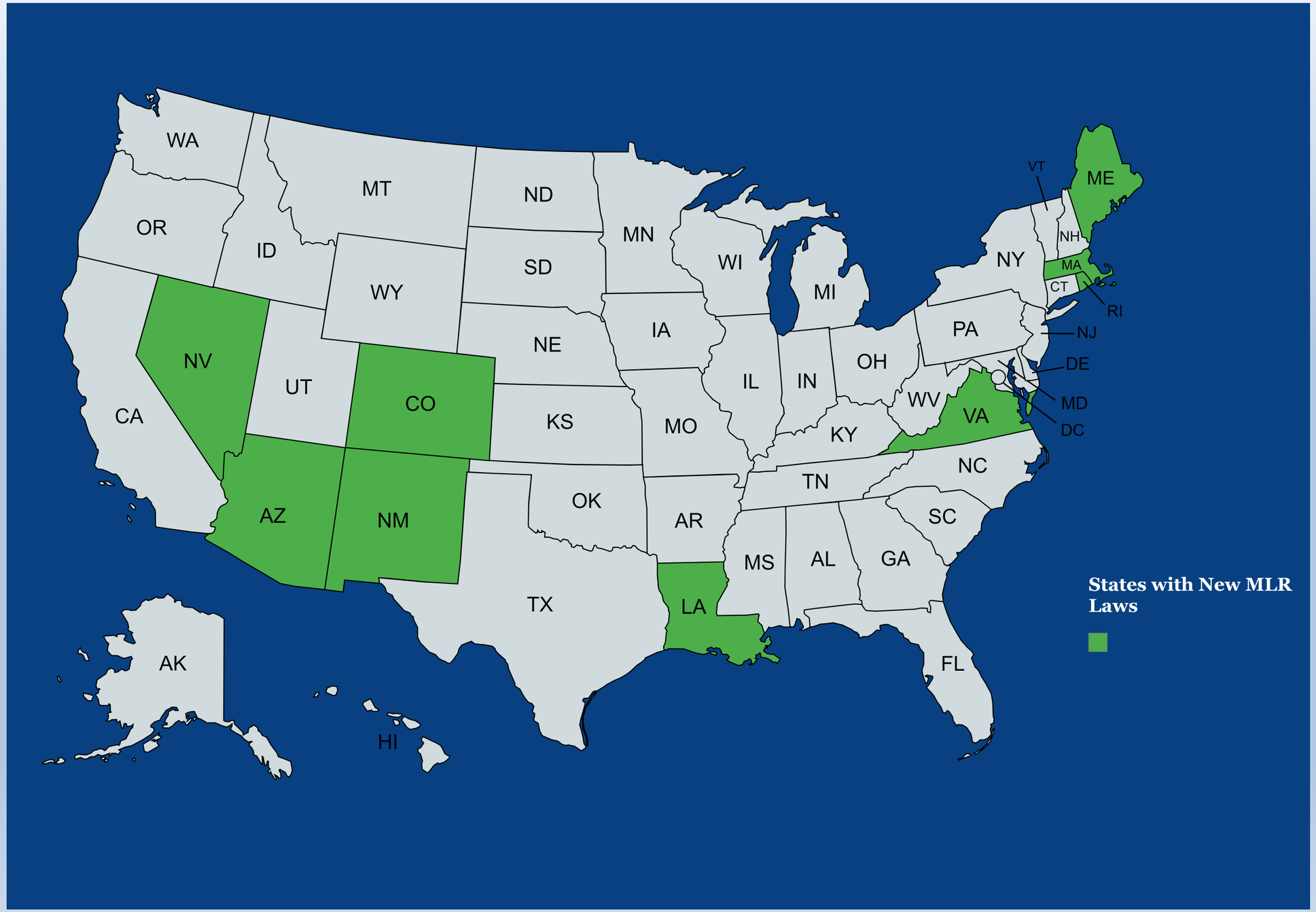
Incentivizes dental insurers to cover needed care and encourages subscribers to get preventative care

**MLR legislation will improve the value of oral health coverage.**

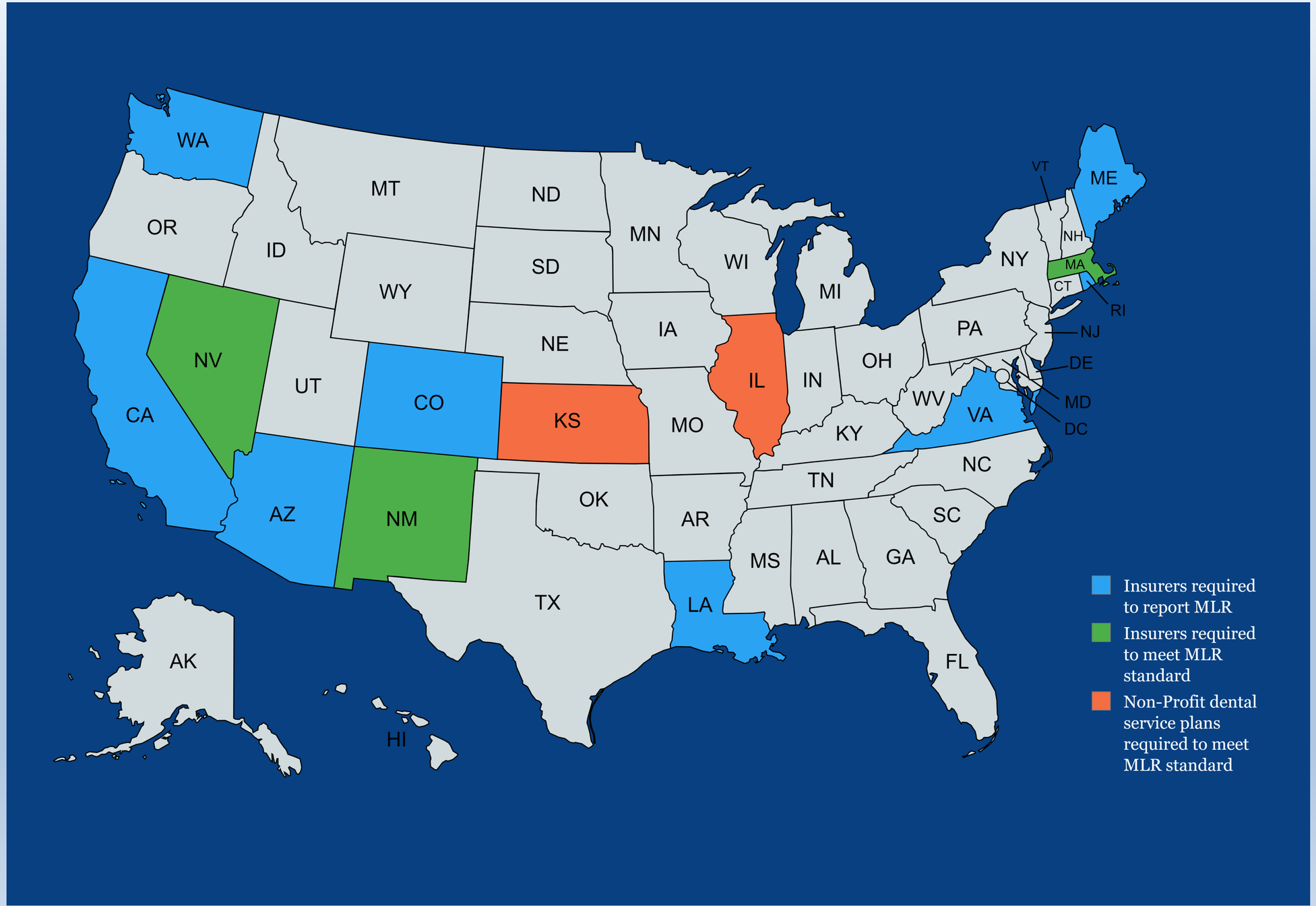
# MLR BILLS FILED IN 2024



# MLR LAWS ENACTED FROM 2022-2024



# MLR LAWS ON THE BOOKS



# HOW DOES MLR HELP PATIENTS?

**Insurance premiums should be spent on patient care**

# HOW DOES MLR HELP PATIENTS?

TRANSPARENCY: Patients deserve to know that their premiums are being spent on actual care.

INCENTIVE STRUCTURE: MLR incentivizes insurers to provide patents with dental care, rather than padding their own profits.

STABILITY: Insurers have many levers to use to meet MLR, which ensures sound investments in patient care.

EVEN PLAYING FIELD: Negates dental insurers' threats to raise premiums rather than control administrative spending; insurers prioritize profits over oral healthcare.

# MASSACHUSETTS MLR BILL:

- **83% RULE**: Dental insurers must spend at least 83% of premiums on dental care and quality improvements.
- **REFUNDS**: If spending is below 83%, insurers must refund excess premiums to policyholders.
- **REPORTING**: Insurers must submit annual financial statements and MLR data to the state, which will be made public.
- **RATE APPROVAL**: The Commissioner can reject proposed rate increases that are excessive, inadequate, or discriminatory.
- **EXEMPTIONS**: Does not apply to self-insured plans or when the insurer acts as a third-party administrator.

# WILL PREMIUMS GO UP?

- Like the Massachusetts MLR Bill, HB 1481 has provisions that protect against premium hikes.

- Section 3 of HB 1481 states that if a dental insurance company asks for a rate increase, but their administrative costs grow too fast, profits are over 2%, or they aren't spending enough on claims, the Commissioner will reject the increase as excessive.

# Ensuring Value for Patients in Dental Insurance

North Dakota DENTAL ASSOCIATION

**Patient dollars should be spent on patient care, not on the profits of big dental insurance companies and their executives. North Dakota should ensure patients get the value they deserve for the dental insurance premiums they pay.**

## Patient Concerns

For too long, multibillion-dollar dental insurance companies have taken advantage of the lack of accountability for how patient premium dollars are used.

The limited available data indicates that around 40% of dental premium dollars are used by insurance companies to cover administrative costs, profits and executive compensation, instead of being directed toward patient care.

Medical Loss Ratio, or MLR, is the portion of insurance premiums that is spent on patient care, rather than insurer overhead costs. All states have laws requiring medical insurance to maintain a minimum MLR, but very few have a similar standard for dental insurance plans.

## Solution

**Patient dollars should go to patient care.**

The North Dakota Dental Association is advocating for legislation requiring that at least 83% of dental insurance premiums be spent on patient care. If insurers fail to meet this standard, they would be required to refund the difference to covered individuals and groups, which is a similar requirement for many major medical plans.

Requiring a higher portion of premium dollars to be spent on patient care can help reduce out-of-pocket costs for patients, making dental care more affordable and encouraging people to go to the dentist.

This policy is popular across the political spectrum: In 2022, 72% of Massachusetts voters approved a similar bill at the ballot box.

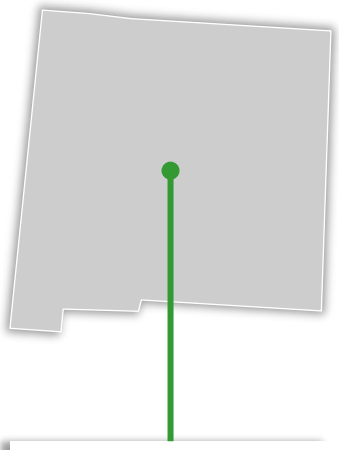
## What Are the Benefits of Medical Loss Ratio (MLR) Laws?

- Patients and employers who pay insurance premiums are guaranteed a good value for their money.
- Dental insurers cannot simply raise premiums without investing the new money in patient benefits.
- Rebate requirements incentivize insurers to meet the threshold and return money to patients and employers if they are overcharged for their premiums.

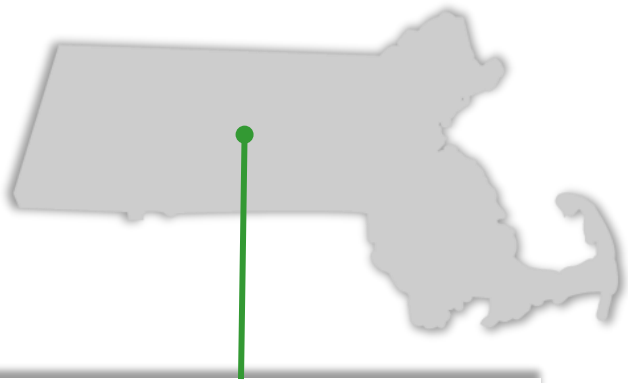
**To learn more about medical loss ratio legislation in North Dakota,**
please contact the North Dakota Dental Association
at 701-223-8870 or William Sherwin at wsherwin@smilenorthdakota.org.

North Dakota DENTAL ASSOCIATION

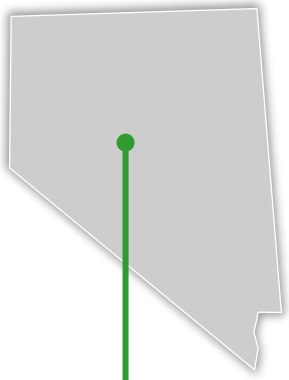
# Medical Loss Ratio Legislation is Gaining Momentum



**New Mexico: 2022**
Dental insurers' plans & coverage must be rejected as unreasonable if they do not meet 65% MLR.



In 2022, **72% of Massachusetts** voters passed **Question 2,** requiring dental insurers to spend at least 83% of premiums on patient care – or refund consumers. Question 2 received more votes than any party's nominee for governor, demonstrating broad bipartisan support.



**Nevada: 2023**
Dental plans are prohibited from selling at an "excessive rate" with MLR under 75%. Commissioner may order insurers to compensate insured affected by excessive rates.

"*Adding a requirement for a medical loss ratio for dental insurance would help promote price transparency and provide incentives to reduce administrative waste. This would help reduce costs for patients*."

Consumer Choice Center,
Policy Note: Dental Insurance Reform

*"It doesn't take much to see how poorly dental insurers are serving people under the current system. More than half of Americans delay getting medical care — or avoid it altogether — because of burdensome costs, and the most frequently skipped form of care is dental … This needs to change, and passing [Question 2] is the first step."*

*Boston Globe,*
Vote Yes on Question 2

*Note: Several other states have passed laws requiring dental insurers to* report *their medical loss ratios. While these laws are a step in the right direction, dental patients need and deserve laws that set a minimum standard for dental MLR.*

**To learn more about medical loss ratio legislation in North Dakota,** please contact the North Dakota Dental Association at 701-223-8870 or William Sherwin at wsherwin@smilenorthdakota.org.

**Dental MLR – Responding to Opposition "Claims"**

THE CLAIM
Dental insurers claims that providers are "against" administrative costs.

THE TRUTH
Dentists support "patient-centered" administrative costs and necessary money spent to provide high quality dental plans – MLR merely provides real incentive for dental insurers to become more efficient.

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THE CLAIM
Insured patients currently have excellent access to dental care.

THE TRUTH
Many patients struggle to afford dental care, even with insurance.

- ADA member dentists regularly see patients who are unable to afford their dental care despite having insurance.
- Insurance companies earn more money when they deny care. There is currently no disincentive to refuse to pay for care.
- Most dental plans currently have an annual maximum benefit that is insufficient to cover major unforeseen dental care needs, leaving patients to bear the costs.

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THE CLAIM
Dental insurance is different from medical insurance, with slimmer profit margins, and can't meet the same standards.

THE TRUTH
Dental carriers are making plenty of profit and their CEOs earn millions every year. They shouldn't be doing so on the backs of dental patients.

- The principles of transparency, value and access to care are the same for dental insurance as they are for medical insurance. Regardless of the type of healthcare, patients deserve to know that the premiums they or their employer are paying are being spent on actual care.
- We would gladly support additional policies to improve dental insurance for patients.
- In the meantime, this is a sensible policy that would improve value and access for dental patients.

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THE CLAIM
A large portion of dental premiums go to administrative costs, which is good for patients.

THE TRUTH
A large portion of dental premiums go to administrative costs, which takes away from patient care.

- Delta's data confirms what we already knew: In some plans, nearly half of premium dollars are spent on non-patient care expenses.
- Excessive spending on executive salaries and corporate profits does not support patients.
- Delta is selectively sharing information about individual and small group plans. Most insured patients are covered by large group plans, where the overhead costs can be much lower – if the insurance carrier is motivated to hold them down.
- Insurers will be held accountable to a fair MLR across all lines of business. Focusing only on individual and small group plans is misleading.
- We know dental insurers can meet the proposed MLR standard because many already do. MLR legislation would bring the others in line.

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THE CLAIM
"Rebates are self-defeating and cost too much to generate."

THE TRUTH

Experience with MLR rebates for medical insurance demonstrate that rebates can be efficiently issued.

- For most plans, employers are paying most of their employees' premiums. Issuing rebates does not require a multitude of checks to individual members on those plans. It requires larger, consolidated rebates issued to employers.
- Many, if not most, rebates will be issued as discounts or credits on insurance premiums, eliminating the need to mail checks.
- The primary purpose of MLR laws is not to force companies to issue rebates. Rather, the goal is to incentivize companies to pay for needed patient care.

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THE CLAIM

To adjust to MLR laws, dental insurers will be forced to reduce or eliminate plans offered, or raise premiums, leading to poorer care for consumers.

THE TRUTH

If dental insurers leave states with MLR laws or raise patient premiums, they are making a choice to do so.

- Medical insurers made these claims when Congress was debating the Affordable Care Act. However, they have remained profitable and competitive.
- Many dental insurers already meet the proposed MLRs, demonstrating that it is possible to be both compliant and profitable.
- Dental insurers' threats to raise premiums rather than control administrative spending demonstrates clearly that insurers prioritize profits over oral healthcare.
- We can include language in the model that requires state approval for the insurers to raise premiums above a certain level (e.g., beyond dental services' consumer price index).

Chair Warrey, Vice Chairs Ostlie / Johnson, and honorable members of the Industry, Business and Labor Committee,

My name is Kami Dornfeld, I'm a practicing dentist in Williston, ND. I write in support of HB1481.

**Dental Premiums Should be Spent on Patient Dental Care**

It seems intuitive that dental insurers would spend a large majority of the money they collect in premiums on patient dental care. However, that is not always the case. North Dakota lawmakers can — and should — fix this problem this legislative session.

Lawmakers can protect North Dakota dental patients by passing legislation requiring that dental insurers spend at least 83% of patient premiums on patient care or refund the difference to patients. This law, known as Medical Loss Ratio, would increase transparency in dental insurance and help keep both premiums and out-of-pocket costs manageable for patients. Health insurance carriers in North Dakota are already required to adhere to these standards, but none such exist for dental insurance.

Nearly half of American adults say it is difficult to afford healthcare costs, and they are more likely to put off oral healthcare than any other type of care. As a dentist, I see this all the time, even with patients who have dental insurance.

There are many ways to make dental insurance work better for patients, so they do not delay or avoid needed care. Simply requiring dental insurers to spend the money they collect in premiums on patient care may be one of the most powerful ways to help right now.

Available data indicates that 25% or more of dental premium dollars are used by insurance companies to cover administrative costs, profits, and executive compensation, instead of being directed to patient care. When every dollar that is shifted away from providing care ends up boosting dental insurers' profits, they have a powerful incentive to spend as little as possible on patient care. A law requiring them to spend at least 83% of premium dollars on patient care will fix that problem.

Dental insurers may claim that they cannot meet this reasonable standard, and that as a result, they will be forced out of business in our state. Patients in North Dakota should not be fooled by this argument. Health insurers have remained profitable under similar standards, and they continue to increase their net income. In addition, some dental insurers already meet this standard. We need a law to bring the others in line.

Skipping dental care can have serious consequences, not just for oral health but for overall health and wellbeing. Poor oral health is linked to conditions such as strokes, as well as poorer academic and employment outcomes. For these reasons and more, we must minimize cost barriers between patients and care.

Patients already know their dental insurance is not serving them well, which is why a bipartisan 72% of Massachusetts voters elected to adopt this policy in November of 2022. North Dakota dental patients deserve the same protections.

Thank you for your time, and please consider a Do Pass recommendation for HB1481.
Respectfully,
Kami Dornfeld

**Testimony in SUPPORT of HB 1481, Dental Loss Ratio**

Chairman Warrey and Members of the House Industry Business and Labor Committee:

My name is Pete Mecham. I am an endodontist in Grand Forks, where I have been in practice for 10 years. I am here today to testify in support of **HB 1481, Dental Loss Ratio**.

My patients come to me for root canals and root end surgeries (apicoectomies). One of the most frustrating things I encounter is when a patient needs care — sometimes urgently — and cannot afford it. This does not just happen with patients who are uninsured. It happens with alarming frequency to patients insured by companies that have found a way to decline to pay for their care.

Data shows that 25% or more of patient premium dollars for dental care are not actually spent on patient care. Instead, they are used for administrative expenses like high executive salaries and shareholder dividends. It's time for that to change.

The Affordable Care Act (ACA) requires medical insurance companies to spend a minimum percentage of premiums on patient care, but our state has no such policy for dental insurers. It is time for that to change.

HB 1481 would require that dental insurers spend at least 83% of patient premiums on patient care. If they fall short, they would have to send rebates to the patients and employers that paid the premiums. This would be a powerful measure to incentivize insurers to pay for more patient care — and it represents an important patient protection measure that will strengthen dental insurance for all.

I ask you to please support North Dakota dental patients by advancing HB 1481.

Pete J. Mecham, DMD, MS

**Testimony in SUPPORT of Bill HB 1481, Dental Loss Ratio**

Chairman Warrey and Members of the House Industry, Business and Labor Committee.

My name is Walter Samuel. I am the President of the North Dakota Dental Association, and we are honored to testify in support of this bill.

When patients purchase dental insurance, they rightly expect that insurance will cover their dental care needs. Unfortunately, dental insurers often find ways to deny paying for care, even when the care is urgently needed.

While medical insurance carriers in North Dakota are required to spend a minimum percentage of patient premiums on healthcare, there is no equivalent standard for dental insurance. Available data indicate that 25% or more of dental premiums are spent on things such as CEO salaries and administration. That means less coverage for North Dakota dental patients.

When patients cannot afford their dental care, including when their insurance will not cover the care they need, they are more likely to postpone or skip getting that care. Skipping dental care can have serious consequences, not just for oral health but for overall health and wellbeing.

In addition to my role with the State Dental Association, I am also a practicing dentist for 15 years. I have seen for myself what can happen to patients when their dental insurers refuse to cover needed care. Having patients who need and elect to have treatment necessary for their dental health, who can't utilize their dental benefits due to denials from the insurance providers doesn't seem fair for a benefit they are paying for. This is becoming more the norm where insurance companies deny benefits to patient's that are paying premiums to make it more difficult to access their "prepaid" benefits/insurance.

Dental insurance companies may tell you this will "force" them to raise patient premiums or that they will not be able to afford to operate in our state if this bill passes. That is just not true. This policy has been in place for more than a decade for medical insurance, and it is time to bring this important patient protection measure to dental insurance.

What this bill would do is protect patients by allowing them to get the dental care they need. This bill would also improve the transparency of dental insurance, simply by applying a policy that has already been successfully implemented in medical insurance.

I ask you to please support HB 1481.

Respectfully,

Walter Samuel D.D.S.
President of the NDDA

February 3, 2025

**RE: House Bill 1481 – OPPOSE**

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[3] ACLI is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long- term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

In North Dakota, dental premiums are on average, about $33 per month[4] and medical premiums are, on average, about $708 per month.[5] At an 85 percent loss ratio, this leaves medical plans with over $100 to cover administrative expenses per member per month. At an 83 percent loss ratio, dental plans would be left with less than $6 to cover administrative expenses per member per month. This small amount would not cover the cost of basic plan operations for even the most cost efficient plans: administration; claims systems; compliance; and state-mandated consumer protections and commissions. If low-cost plans cannot cover their administrative expenses under the 83 percent loss ratio, those plans may be forced to no longer offer in North Dakota or to raise premiums to cover increased costs.

In Massachusetts, the only state to adopt a similar, mandatory dental loss ratio (through ballot initiative), the market for dental insurance has contracted significantly, with at least 8 fewer carriers in the small group and individual markets, a 25 percent decline, since the imposition of the DLR in 2022. An independent analysis of similar bills indicates that a mandated dental loss ratio of 85 percent could raise premiums for dental coverage by 114 percent for small groups, and 78 percent for the individual market.[6] The analysis highlighted the risk that such a sudden and rapid increase in the cost of coverage will lead many small businesses to forgo dental plans for their employees and reduce access to oral health care.

**Dental Plans and Oral Health**

House Bill 1481 has the potential to dramatically reduce the availability of dental coverage in North Dakota with negative effects on access to oral health care. Dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Under a typical dental plan, preventive care is covered at 100 percent cost sharing to incentivize utilization and a regular relationship with a dentist. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

Dental insurance has been shown to be highly price sensitive and an increase in premiums may lead to a reduction in dental coverage. Losing coverage often means patients must pay full list price for their dental care and a cleaning may cost hundreds of dollars out of pocket. As a result, many people without dental coverage skip regular preventive services to reduce costs and in the long term this increases their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions. For these reasons, we oppose House Bill 1481 and urge you not to advance the legislation.

Thank you for your consideration. We look forward to working with you to develop alternative avenues to evaluate the value of dental benefits in North Dakota.

Respectfully submitted,

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[4] NADP, 2024. Dental Benefits Report. (link)

[5] "Average Annual Singel Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation (2023). Employers typically contribute about $613 per month while employees typically contribute about $95 per month.

[6] AB 2028 Medical Loss Ratios Report final to Legislature 04122024.pdf

Bianca Balale
Director of Government Relations
National Association of Dental Plans

Owen Urech
Senior Policy Advisor, Product Policy
AHIP

Alex Young
Legislative Director, State Relations
ACLI

**Patient Dental Insurance Dollars Should Be Spent on Patient Care**

I'm Dr.Tessa Lagein and I've been a dentist for 12 years in Valley City, ND. I live in a small town where patients aren't only our patients, but are also our children's coaches, teachers, caregivers etc that we have grown to care about more then just the care of their mouth and oral care.

Patients who pay monthly premiums for dental insurance expect that insurance will pay for their dental care. As a dentist, unfortunately, I have seen that this is not always the case, causing major problems for patients. The State Legislature can provide a solution by requiring that at least 83% of patients' dental insurance premium dollars are spent on patient dental care.

I have this discussion far too often with many of my patients. Once treatment options have been viewed and determined for the patient's best interest, they bring up the same question. "How much does my insurance cover?." It is a very difficult discussion to have. It often is the determining factor for their dental care, not what the best clinical choice for their body is. All this money spent for dental coverage, yet very little is paid by the insurance company toward treatment. This situation, unfortunately, leads to delayed treatment, or sometimes, no treatment at all.

This problem isn't unique to my patients, or patients in North Dakota. Nearly half of American adults say they find it difficult to afford healthcare costs. They also say they are more likely to put off oral healthcare than any other type of care. When patients can not get the dental treatments they need, oral health problems can get much worse, leading to more extensive and expensive treatment down the road. Research has also shown that poor dental health is linked to conditions such as strokes and academic and employment challenges. Sadly, I see these real-life consequences in my practice. According to available data, a quarter of dental premiums are currently being spent by insurance companies on things like executive salaries, administrative costs and boosting profits — none of which directly benefit patients. Some insurers spend far more. While highly paid executives and shareholders reap the benefits, patients pay the price.

The State legislature can help protect dental patients by requiring that dental insurers spend at least 83% of the premiums they collect on patient care. If insurers do not meet this standard, they must refund the difference to patients or, if an employer is paying the premiums, to the employer. This law, known as Medical Loss Ratio, would increase transparency in dental insurance and help keep both premiums and out-of-pocket costs more manageable for patients.

It is also a tried-and-true strategy. Medical insurance carriers in Our State are already required to adhere to such standards, but currently, Our State does not apply the same standard to dental insurance. While dental insurers may say this is an unreasonable standard that will force them to stop selling insurance in Our State, we know this is simply untrue. Health insurers remain profitable under similar standards, and have in fact continued to increase their net income.

Some dental insurers already meet the 85% standard, but with no transparency and no minimum standard, some fall short. It is time to pass a law to ensure all patients get good value for the premiums they pay.

Dental patients know their dental insurance is not serving them well. That is why 72% of Massachusetts voters from across the political spectrum voted to adopt Medical Loss Ratio for dental insurance in November. Our State patients deserve the same protections.

Our lawmakers have the power to make it happen, and they should do so without delay this year.

Thank you for your consideration

Dr.Tessa Lagein

02/03/2025

DELTA DENTAL®

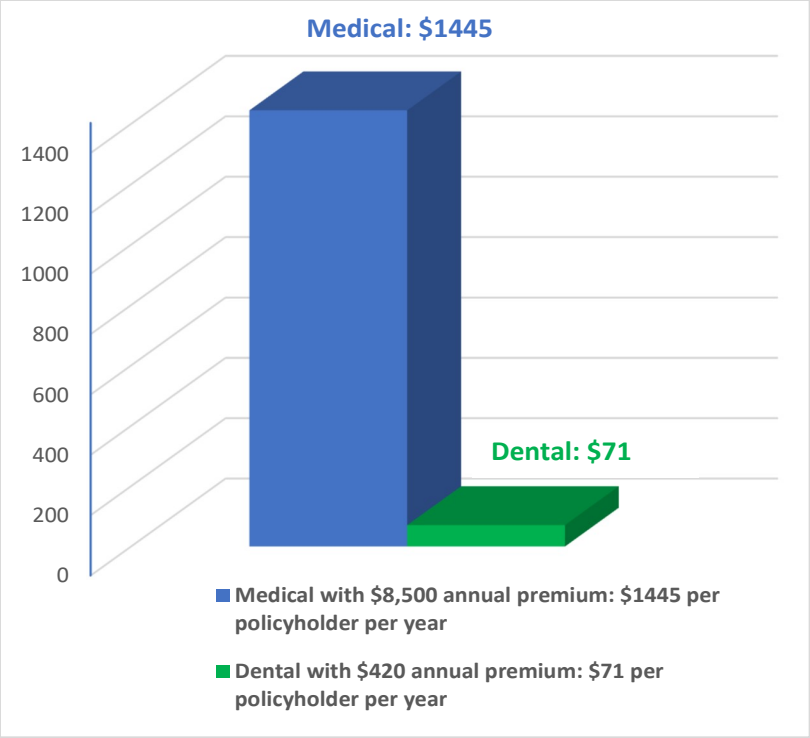
## HB1481 (THE 83% DENTAL LOSS RATIO BILL) IS WRONG FOR NORTH DAKOTA

**The Bill Is Unnecessary Because North Dakota Already Regulates Dental Premiums and Policies**. Dental carriers already must file their premium rates and policy forms with the North Dakota Insurance Department before use in North Dakota. The Insurance Department may disapprove rates or forms if the benefits provided are not reasonable in relation to the premiums charged, or are unfair or inequitable.[1] As a result, under existing law, the Insurance Department already determines that dental premiums are reasonable for the benefits provided and supported by sound actuarial data. HB1481 is unnecessary.

**The Bill Is Impractical Because Dental Coverage is Different Than Medical Coverage**. The dental loss ratio legislation in HB1481 is based on medical loss ratio provisions in the Affordable Care Act. As noted below, dental coverage is much different than medical coverage, resulting in far different loss ratio expectations. For this reason, Congress rejected mandating dental loss ratios in the ACA.

The fixed costs of administering dental plans require disproportionately larger portions of revenue than medical plans (i.e., a lower loss ratio). Dental premiums are often about 1/20th the cost of medical premiums, but dental carriers have many of the same fixed costs for operations.

### 83% Loss Ratio Medical v. Dental—Available Funds to Operate Insurer (Per Policyholder):




**Examples of Fixed Costs:**

- Claims processing
- Customer service
- IT and data security
- Actuarial, underwriting, finance, accounting
- Provider credentialing & enrollment
- Member enrollment & eligibility
- Policy issuance, member ID cards
- Broker commissions
- Insurance (cyber security, property, workers' comp, etc.)
- Government rate & policy filings & compliance
- Philanthropic & community spending
- Building and office space
- Personnel & administrative costs

[1] *See e.g* NDCC 1.26-30

As the above figure illustrates, a medical plan with a $708 monthly premium and 83% loss ratio has $1,445 per year ($120.42 per month) for benefit administration and operations, but a dental plan with a $35 monthly premium and 83% loss ratio only has $71 per year ($5.92 per month) for benefit administration and operations—even though medical and dental plans have similar types of fixed operational costs.

**The Bill's Unintended Consequences Are Bad for Patients.** Massachusetts recently adopted a ballot initiative requiring an 83% dental loss ratio. The standard went into effect in 2024. **No state has adopted the Massachusetts dental loss ratio standard**—but at least 20 states have rejected it. Unintended consequences from HB1481 include:

- **Premiums increases.** Insurance experts predict that dental carriers will have to raise premiums to meet a loss ratio mandate. In 2024, the State of California studied *proposed* legislation similar to HB1481 and found that an 85% dental loss ratio would increase individual and small group premiums by 78-266%. The California Legislature rejected the dental loss ratio proposal. If dental premiums increase beyond purchasers' budgets, people and employers will stop buying dental coverage and employers will shift more costs to employees.
- **Fewer people receiving treatment**. According to one study, individuals with dental insurance were 49% more likely to have visited the dentist for check-ups or cleanings in the last 6-months.[2] If purchasers are forced to drop dental coverage due to increased premiums caused by this legislation, fewer people will receive oral health care—and their oral health will suffer.
- **Dental plan Participation**. While it is still too early for the impacts of the Massachusetts dental loss ratio law on dental markets to be fully realized, **at least eight (8) insurance companies have already exited at least one market in Massachusetts** since the dental loss ratio standard took effect. More may follow suit. No carriers have entered the market to fill this vacuum.

**Unlevel Playing Field.** Most large employers self-fund their dental benefits. Nationwide, self-insured plans are estimated to cover at least 45% of commercial dental plan enrollees. States are preempted by federal law from regulating self-funded employee benefit plans. As a result, a state dental loss ratio mandate would impact only a portion of the overall dental coverage market: namely, dental plans bought by individuals and smaller-sized employers. These same purchasers would therefore bear the brunt of any premium increases caused by the legislation.

[2] National Association of Dental Plans Consumer Survey

Features

# Health Policy Perspectives

# Why we need more data on the dental insurance market

Marko Vujicic, PhD; Niodita Gupta, MD, MPH, PhD; Kamyar Nasseh, PhD

Economics teaches us that competition in markets is a good thing. The health care market is a special market, and competition among providers and insurers is closely monitored by the Federal Trade Commission (FTC). In recent years, the FTC has intervened on several occasions to prevent mergers and acquisitions in health care markets that would have reduced competition to a degree deemed harmful to consumers.[1] The theory goes that if, for example, there is only 1 hospital group in town, the hospital will end up charging patients more for its services than if there were many hospitals in town. The empirical evidence tends to confirm this, with less competition among providers leading to higher prices[2] for patients and less competition among insurers leading to higher premiums[3] and lower provider payment rates.[4] Competition matters.

So let us talk about competition in different parts of the dental care sector. The care delivery side is highly fragmented. Dentistry is the last cottage industry in health care composed mostly of small firms and few large firms with any appreciable market share. The most recent data indicate that 88% of dental offices in the United States have 3 or fewer dentists (Health Policy Institute, unpublished data, 2016). This is certainly changing over time, as more and more practices consolidate.[5] But for now, the dental care delivery side for the most part is highly fragmented.

The insurer side, as the figure[6,7] shows, is a different story. The data summarize the market share of various dental insurance carriers in California. This is the first time ever, as far as we know, that data of this nature were made publicly available. This was a big deal for us because the American Dental Association Health Policy Institute has been trying to obtain dental insurer market data for years, not just for California but for all states. We tried several avenues, including requests to the National Association of Insurance Commissioners and the National Association of Dental Plans. The data we obtained were made available as part of California's efforts to monitor the medical loss ratio of medical and dental insurance carriers under the Affordable Care Act (ACA).

The data for California show 1 dominant carrier and a long tail of carriers with much smaller market shares. Delta Dental of California has the highest market share (40.3%) and Metropolitan Life Insurance Company has the second highest (8.0%). Furthermore, 31 of 52 insurers have a market share of less than 1%. The Herfindahl-Hirschman Index (HHI) is a fancy way economists measure the competitiveness of markets. Markets in which the HHI is between 1,500 and 2,500 are considered to be moderately concentrated, whereas levels greater than 2,500 are considered to be highly concentrated.[8] The HHI for the dental insurance market in California is 1,813.

What are possible implications of a moderately concentrated dental insurance market? Market concentration could result in higher premiums for consumers or lower reimbursement for providers.[9] More in-depth research is needed, but our preliminary analysis of newly released premiums data indicates that average premiums for most of Delta Dental of California beneficiaries actually decreased from 2014 through 2016 after adjusting for inflation (Table).[6] We do not have access to data for prior years. We also do not have access to data on Delta Dental of California's reimbursement rates to dentists, but a recent lawsuit settlement suggests reimbursement rates have indeed been declining.[10] Moreover, statewide data covering all dental insurers indicate inflation-adjusted reimbursement rates have declined in recent years in California.[11] If more data were publicly available, a more thorough analysis could be conducted. In the meantime, our take on these preliminary data is that market power is being leveraged by insurers primarily to control costs rather than to increase premiums.

Cost control measures, unquestionably, are a good thing for beneficiaries if such measures do not adversely affect access to dentists, quality of care, or benefit levels. Or, more formally, if the adverse effects are outweighed by savings in premiums. Here again we have another important area for further study. The evidence we are aware of—and it is limited—suggests that younger patients are more willing to trade provider choice for savings in premiums than older patients.[12]

Another way to examine the extent to which market power might affect premiums and provider payments is through medical loss ratio (MLR) data. The MLR measures the share of premium revenue that is spent on patient care. The ACA included a provision that MLRs for medical insurers must be at least either 80% or 85%, depending on the type of insurance.

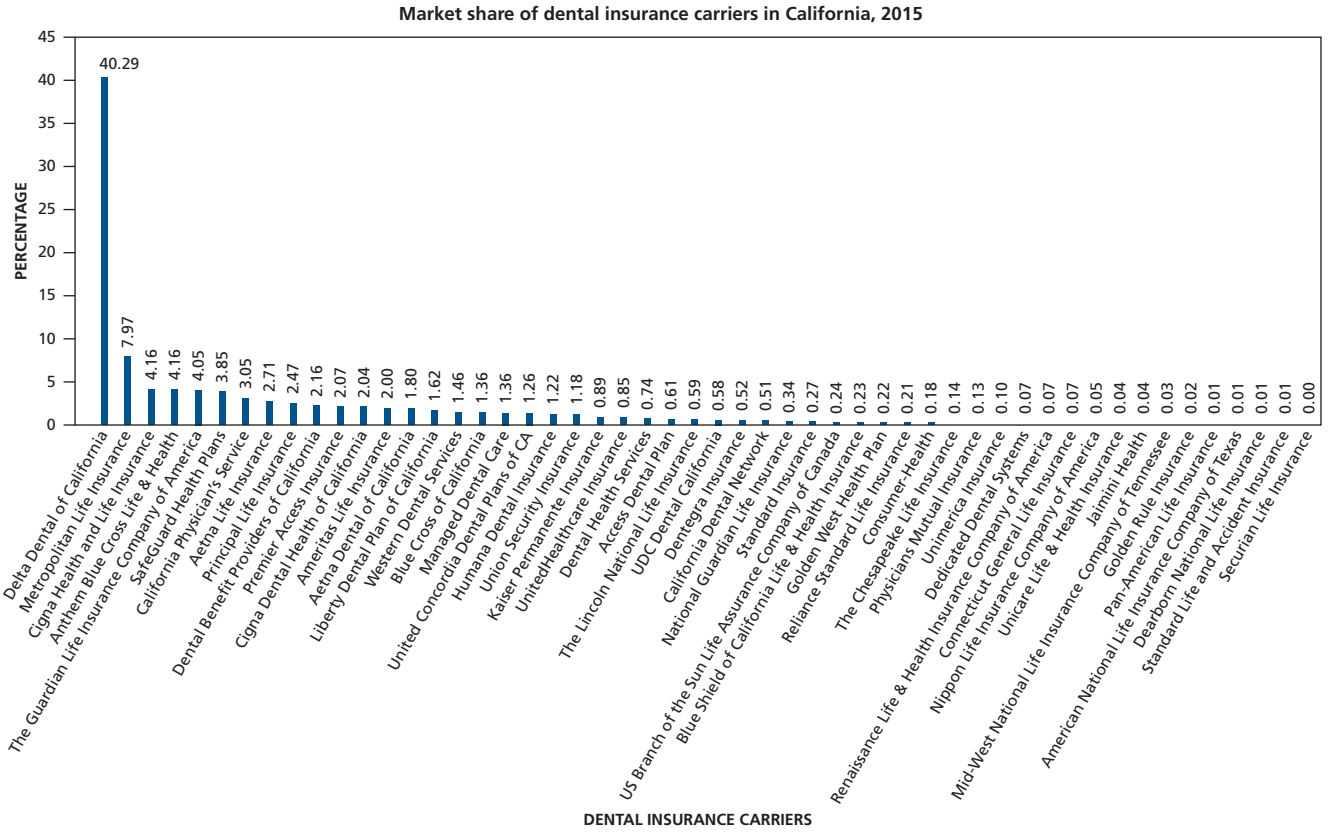



**Figure.** The total number of covered lives in California in 2015 was 9,891,539 (as of March 31, 2016). The number of covered lives were aggregated to the insurer level. The market share of covered lives for each insurer was calculated as the number of covered lives by the insurer in 2015 (as of March 31, 2016) divided by the total number of covered lives in California in 2015 (as of March 31, 2016). *Source: American Dental Association Health Policy Institute analysis of data from California Department of Managed Health Care*[6] *and California Department of Insurance.*[7]

In other words, insurers must spend at least 80% or 85% of total premium revenue on patient care.[13] In 2015, this MLR provision resulted in an average rebate paid by insurers to beneficiaries of $138 per family.[14]

The MLR provision under the ACA does not apply to dental insurers. However, in California, a law was put in place in 2014 to simply collect MLR data on dental insurers.[15] We examined these data and found that among the 52 dental insurers in California, only 6 had MLR levels of at least 80%, including Delta Dental of California, the market share leader. (The dental MLR was calculated as total incurred claims/[total direct premium earned total federal and state taxes and fees to be excluded from premium]. The aggregate percentages at the insurer level were calculated by adding the total incurred claims, total direct premium earned, and total federal and state taxes and fees to be excluded from the premium at the insurer level and then using the aforementioned formulas. The amounts included for this analysis were noted as of March 31, 2016, in the dental MLR reports.) Eight carriers had MLR levels below 50%, meaning less than one-half of premium revenue was spent on patient care. These preliminary data suggest that expanding the ACA's MLR provision to dental insurance could lead to premium reductions or enhanced outlays for dental care, both of which would presumably benefit consumers.

In big picture terms, our analysis of the California dental insurance market indicates a moderate level of concentration by FTC standards, with 1 dominant carrier. We have outlined some potential effects this level of market concentration might have on beneficiaries and providers, based on our interpretation of the data made available so far. Our analysis is based on 1 state and cannot be generalized to other markets. We urge other state agencies to make similar data publicly available. It is encouraging that several states, including Washington,[16] Rhode Island,[17] Illinois,[18] and Massachusetts,[19,20] are proactively pursuing measures to improve data transparency in the dental insurance market. At the national level, we urge organizations such as the National Association of Insurance Commissioners and the National Association of Dental Plans to make data transparency a priority when it comes to dental insurance. This is the only way researchers can study the implications of dental insurance market dynamics. ■

https://doi.org/10.1016/j.adaj.2017.11.016

**Table.** Premiums and covered lives for Delta Dental of California.*

| DENTAL PLAN TYPE | COVERED LIVES IN 2016† | ESTIMATED AVERAGE MONTHLY PREMIUM | | | |
|---|---|---|---|---|---|
| | | 2014 | 2015 | 2016 | Percentage Change (2014-2016) |
| **Large Group DPPO‡** | 2,628,184 (69) | $43.18 | $42.56 | $41.44 | −4.05 |
| **Large Group DHMO§** | 683,667 (18) | $14.64 | $14.40 | $14.00 | −4.34 |
| **Small Group DPPO** | 251,858 (7) | $53.45 | $50.55 | $49.37 | −7.64 |
| **Individual DHMO** | 142,040 (4) | $10.43 | $9.83 | $11.22 | 7.63 |
| **Small Group DHMO** | 76,771 (2) | $18.27 | $17.30 | $16.67 | −8.77 |
| **Individual DPPO** | 10,020 (< 1) | $32.46 | NA¶ | $52.84 | 62.82 |

*The average monthly premium was calculated as the total direct premiums earned (as of March 31 of the next year) divided by the number of member months (as of March 31 of the next year). All amounts are adjusted to 2016 dollars using the Consumer Price Index for Dental Services. Premium data for individual DPPO plans were unavailable for 2015. The percentage of covered lives for each plan is the number of covered lives for that plan divided by the total number of covered lives by Delta Dental of California in 2016. *Source: American Dental Association Health Policy Institute analysis of data from California Department of Managed Health Care.*[6]; †Values are n (%); ‡DPPO: Dental preferred provider organization; §DHMO: Dental health maintenance organization; ¶NA: Not applicable.

Dr. Vujicic is the chief economist and the vice president, Health Policy Institute, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611, e-mail vujicicm@ada.org. Address correspondence to Dr. Vujicic.

Dr. Gupta is a health services researcher, Health Policy Institute, American Dental Association, Chicago, IL.

Dr. Nasseh is a health economist, Health Policy Institute, American Dental Association, Chicago, IL.

This column represents the opinions of the author and not necessarily those of the American Dental Association.

**Disclosure.** The authors did not report any disclosures.

To receive Health Policy Institute reports and commentary, follow the ADA Health Policy Institute on Twitter @adahpi.

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25.1250.02001
Title.

Prepared by the Legislative Council staff for Representative Kasper
January 24, 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.

**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.~~1. 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 in the dental services consumer price index;

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 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 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 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.

# 2025 HOUSE STANDING COMMITTEE MINUTES

**Industry, Business and Labor Committee**
Room JW327C, State Capitol

HB 1481
2/17/2025

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.

10:18 a.m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Member Absent: Representative Christy

**Discussion Topics:**

- Ability to implement
- Smaller carriers
- Duplicative language removed
- Incorporate some flexibility
- Aggerate loss ratio, not plan ratio
- Claim data when price
- Additional staff.

10:39 a.m. Representative Koppelman moved Adopt Amendment LC #25.1250.02001, #37888 and further amend to include 1000 lives or less and to add the effective date of 1-1-2027.

10:40 a.m. Representative Kasper seconded the motion.

Voice vote.

Motion passed.

10:40 a.m. Representative Koppelman moved Do Pass as amended.

10:41 a.m. Representative Kasper seconded the motion.

| Representatives | Vote |
|---|---|
| Representative Jonathan Warrey | Y |
| Representative Mitch Ostlie | Y |
| Representative Landon Bahl | Y |
| Representative Collette Brown | Y |
| Representative Josh Christy | AB |
| Representative Lisa Finley-DeVille | Y |
| Representative Karen Grindberg | Y |

| | |
|---|---|
| Representative Jorin Johnson | Y |
| Representative Jim Kasper | Y |
| Representative Ben Koppelman | AB |
| Representative Dan Ruby | Y |
| Representative Mike Schatz | Y |
| Representative Austin Schauer | Y |
| Representative Daniel R. Vollmer | Y |

Motion passed 11-2-1.

10:49 a.m. Representative Koppelman will carry the bill.

10:49 a.m. Chairman Warrey closed the meeting.

*Diane Lillis, Committee Clerk*

25.1250.02003
Title.03000

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

Sixty-ninth
Legislative Assembly
of North Dakota

**PROPOSED AMENDMENTS TO**

2-17-25

# 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.

2 of 4

~~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

3 of 4

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.

# REPORT OF STANDING COMMITTEE
# HB 1481

**Industry, Business and Labor Committee (Rep. Warrey, Chairman)** recommends **AMENDMENTS (25.1250.02003)** and when so amended, recommends **DO PASS** (11 YEAS, 2 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). HB 1481 was placed on the Sixth order on the calendar.

25.1250.02001
Title.

Prepared by the Legislative Council staff for Representative Kasper
January 24, 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.

**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.~~1. 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 in the dental services consumer price index;

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 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.~~

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~~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.~~

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~~6.~~2. a. If the annual dental loss ratio for a dental benefit plan is less than eighty-three 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 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

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(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.

**2025 SENATE HUMAN SERVICES**

**HB 1481**

# 2025 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Lincoln Room, State Capitol

HB 1481
3/10/2025

| Relating to dental insurer rate requirements; and to provide an effective date. |
|---|

9:05 a.m. Chairman Lee called the meeting to order.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

**Discussion Topics:**

- Annual Percentage Rate Adjustment
- Structure of Insurance Plans
- Self-funded plans
- Dental Premiums in Relation to ACA
- End Coil Model

9:06 a.m. Representative Jim Kasper introduced the bill and submitted testimony in favor #40083.

9:17 a.m. William Sherwin, Executive Director of The North Dakota Dental Association, testified in favor and submitted testimony #39615, #39616, #39617, #39618, #and #39619.

9:46 a.m. Dr. Bradley King testified in favor.

9:56 a.m. Al Berg testified in opposition and submitted testimony #39870.

10:15 a.m. Dennis Pathroff, Lobbyist, The American Council of Life Insurers, testified in favor.

10:19 a.m. Ben Wogsland, Vice President of Government Affairs with Delta Dental of Minnesota, testified in opposition and submitted testimony #39861.

10:32 a.m. Alex Kelsch, Lobbyist with AHIP, testified in opposition and submitted testimony #39879.

10:34 a.m. Bianca Balale, Director of Government Relations with National Association of Dental Plans, testified in opposition and submitted testimony #39764 and #39766.

10:41 a.m. Kate McCown, Vice President of Compliance with Ameritas Life Insurance Corp., testified in opposition and submitted testimony #39847.

10:46 a.m. Chrystal Bartuska, ND Insurance Department, testified in neutral.

**Additional written testimony:**

#39890, #39889, #39871, #39773, #39763, #39762, #39761, #39760, #39758, #39739, #39704, #39679, #39651, #39638, #39626.

10:47 a.m. Chairman Lee closed the hearing.

*Andrew Ficek, Committee Clerk*

#39615

North Dakota DENTAL ASSOCIATION

ADA®

# MEDICAL LOSS RATIO FOR DENTAL INSURANCE

WWW.SMILENORTHDAKOTA.ORG
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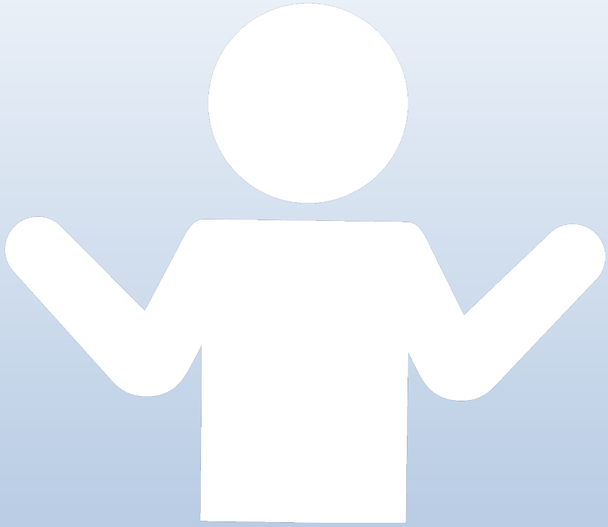
What is Medical Loss Ratio (MLR)?

How does it help patients?



What is the difference between general health insurance and dental insurance?

What progress has been made in the states?

# THE DIFFERENCE BETWEEN GENERAL HEALTH INSURANCE AND DENTAL INSURANCE

General Health Insurance: Provides unexpected/catastrophic coverage

Dental Insurance: Provides only basic preventative care

## GENERAL HEALTH INSURANCE

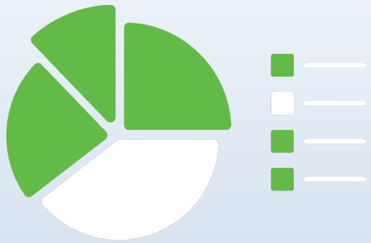
- No annual limit; unused benefits do not roll back into insurers' bank
- Risk-based
- Able to spread risk
- Plan design encourages prevention and catastrophic care costs

## DENTAL INSURANCE

- Limited annual care expenditure
- Insurance payments are generally low (lower premiums)
- Designed to cover basic preventative care rather than treatment of dental disease
- Insurance typically covers 50% of costs for major issues (usually capped at $1,000 per year)
- Tends to be treated as a stipend. Many employers do not cover or offer it at all

# SUMMARY

| Plan Components | Medical | Dental |
|---|---|---|
| Annual Limit on Expenditures | x | ✓ |
| Risk Bearing-Spreading Risk | ✓ | x |
| Preexisting Condition Limits | x | ✓ |
| Must Comply with PPA | ✓ | x |
| Deductibles | ✓ | ✓ |
| Co-Pay/Coinsurance | ✓ | ✓ |
| Prior Authorizations | ✓ | ✓ |



# WHAT IS MEDICAL LOSS RATIO (MLR)?

**The percentage of insurance premiums spent on patient care, rather than on overhead costs, like executive salaries and administration.**

# HB 1481 CONSUMER PROTECTIONS

1

Adds transparency to dental insurance

2

Establishes a minimum percentage of premiums that dental insurers must spend on patient care

3

Requires carriers who do not meet the minimum percentage to refund the difference to covered patients and groups

# HOW THIS BILL HELPS PATIENTS

Improves the value employers and patients get for their premium dollars

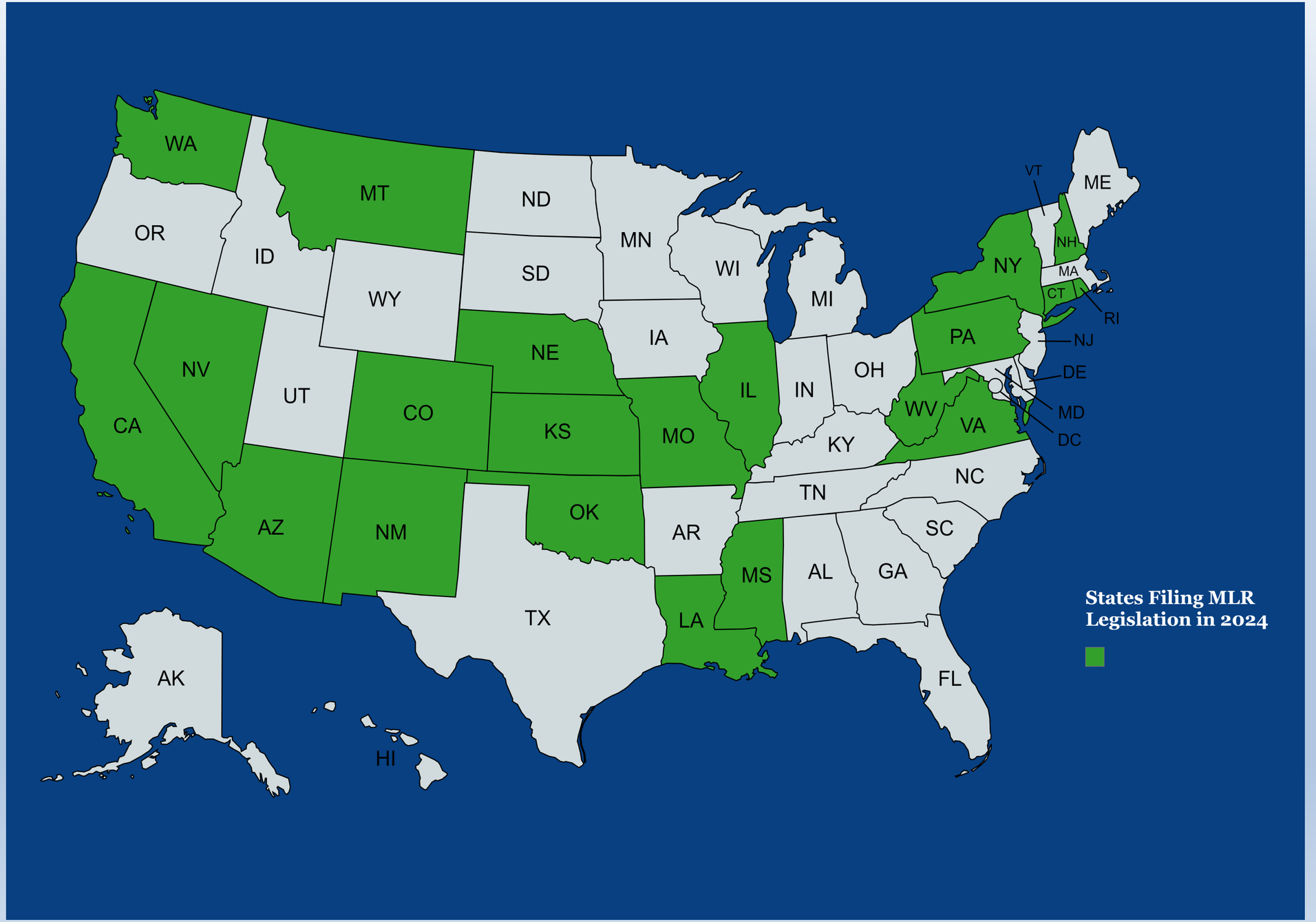
Makes dental insurance more reliable

Patients will get the care they need, when they need it

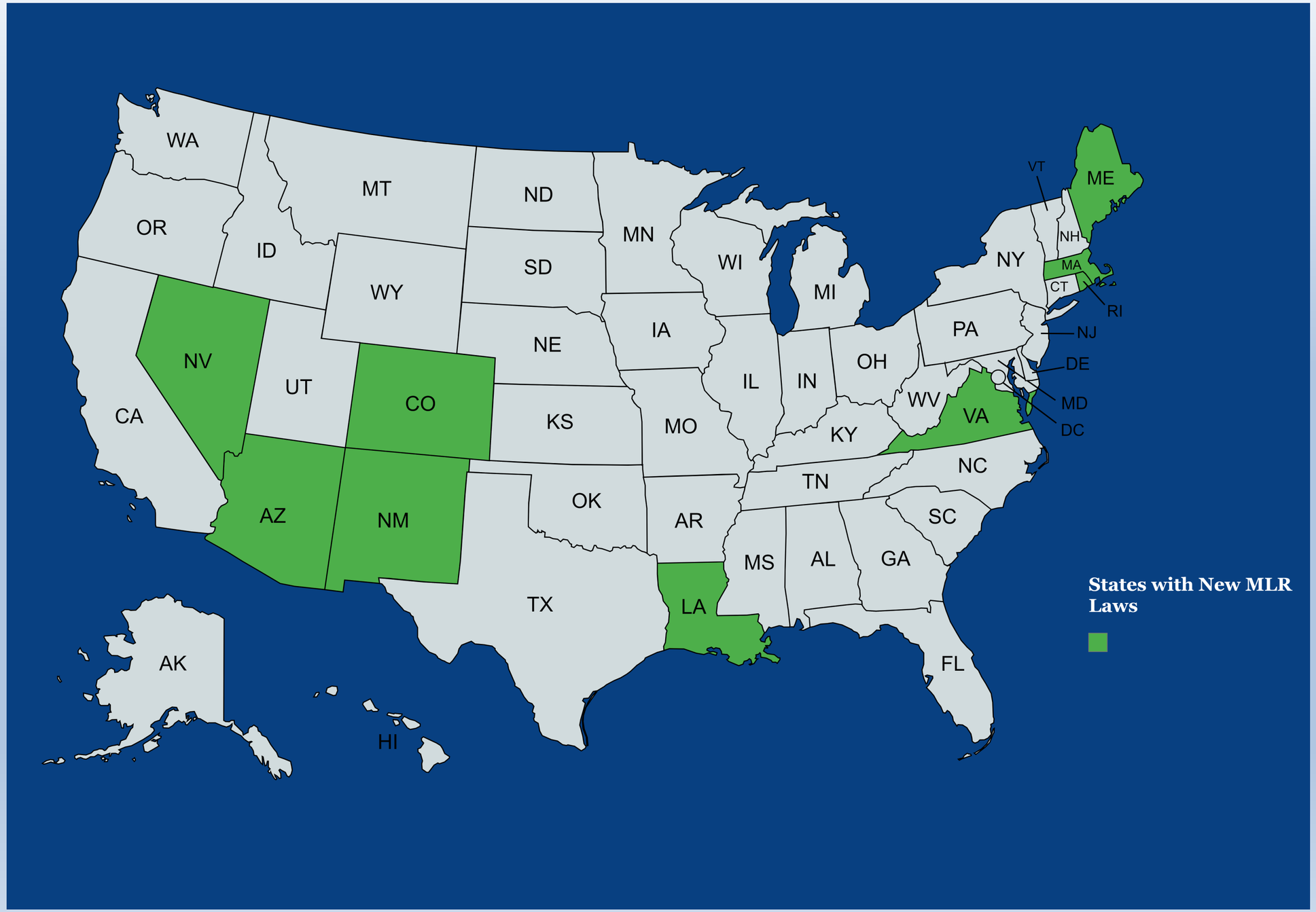
Incentivizes dental insurers to cover needed care and encourages subscribers to get preventative care

**MLR legislation will improve the value of oral health coverage.**

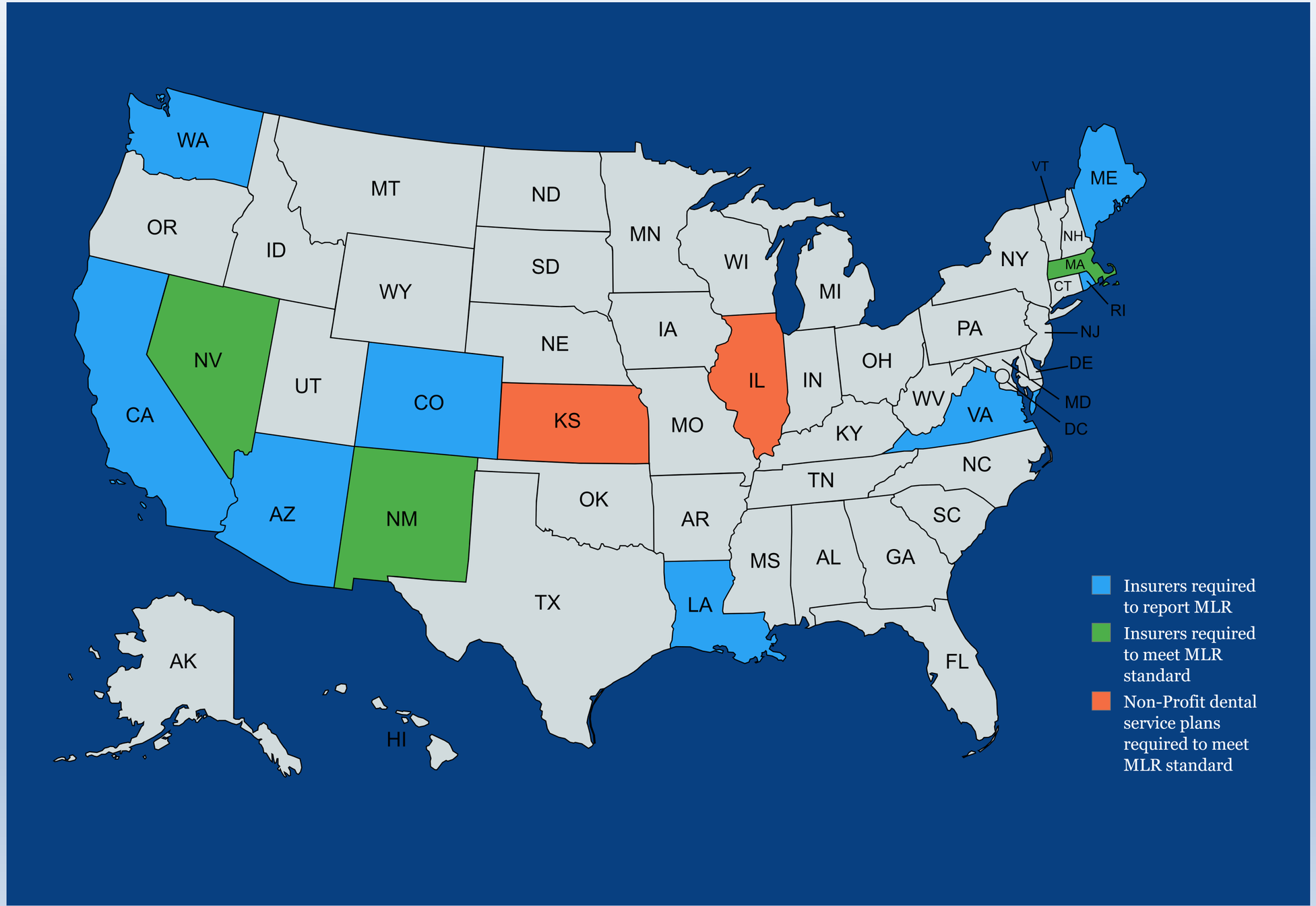
# MLR BILLS FILED IN 2024



# MLR LAWS ENACTED FROM 2022-2024



# MLR LAWS ON THE BOOKS



# HOW DOES MLR HELP PATIENTS?

**Insurance premiums should be spent on patient care**

# HOW DOES MLR HELP PATIENTS?

TRANSPARENCY: Patients deserve to know that their premiums are being spent on actual care.

INCENTIVE STRUCTURE: MLR incentivizes insurers to provide patents with dental care, rather than padding their own profits.

STABILITY: Insurers have many levers to use to meet MLR, which ensures sound investments in patient care.

EVEN PLAYING FIELD: Negates dental insurers' threats to raise premiums rather than control administrative spending; insurers prioritize profits over oral healthcare.

# MASSACHUSETTS MLR BILL:

- **83% RULE**: Dental insurers must spend at least 83% of premiums on dental care and quality improvements.
- **REFUNDS**: If spending is below 83%, insurers must refund excess premiums to policyholders.
- **REPORTING**: Insurers must submit annual financial statements and MLR data to the state, which will be made public.
- **RATE APPROVAL**: The Commissioner can reject proposed rate increases that are excessive, inadequate, or discriminatory.
- **EXEMPTIONS**: Does not apply to self-insured plans or when the insurer acts as a third-party administrator.

# WILL PREMIUMS GO UP?

- Like the Massachusetts MLR Bill, HB 1481 has provisions that protect against premium hikes.

- Section 3 of HB 1481 states that if a dental insurance company asks for a rate increase, but their administrative costs grow too fast, profits are over 2%, or they aren't spending enough on claims, the Commissioner will reject the increase as excessive.

Features

# Health Policy Perspectives

# Why we need more data on the dental insurance market

Marko Vujicic, PhD; Niodita Gupta, MD, MPH, PhD; Kamyar Nasseh, PhD

Economics teaches us that competition in markets is a good thing. The health care market is a special market, and competition among providers and insurers is closely monitored by the Federal Trade Commission (FTC). In recent years, the FTC has intervened on several occasions to prevent mergers and acquisitions in health care markets that would have reduced competition to a degree deemed harmful to consumers.[1] The theory goes that if, for example, there is only 1 hospital group in town, the hospital will end up charging patients more for its services than if there were many hospitals in town. The empirical evidence tends to confirm this, with less competition among providers leading to higher prices[2] for patients and less competition among insurers leading to higher premiums[3] and lower provider payment rates.[4] Competition matters.

So let us talk about competition in different parts of the dental care sector. The care delivery side is highly fragmented. Dentistry is the last cottage industry in health care composed mostly of small firms and few large firms with any appreciable market share. The most recent data indicate that 88% of dental offices in the United States have 3 or fewer dentists (Health Policy Institute, unpublished data, 2016). This is certainly changing over time, as more and more practices consolidate.[5] But for now, the dental care delivery side for the most part is highly fragmented.

The insurer side, as the figure[6,7] shows, is a different story. The data summarize the market share of various dental insurance carriers in California. This is the first time ever, as far as we know, that data of this nature were made publicly available. This was a big deal for us because the American Dental Association Health Policy Institute has been trying to obtain dental insurer market data for years, not just for California but for all states. We tried several avenues, including requests to the National Association of Insurance Commissioners and the National Association of Dental Plans. The data we obtained were made available as part of California's efforts to monitor the medical loss ratio of medical and dental insurance carriers under the Affordable Care Act (ACA).

The data for California show 1 dominant carrier and a long tail of carriers with much smaller market shares. Delta Dental of California has the highest market share (40.3%) and Metropolitan Life Insurance Company has the second highest (8.0%). Furthermore, 31 of 52 insurers have a market share of less than 1%. The Herfindahl-Hirschman Index (HHI) is a fancy way economists measure the competitiveness of markets. Markets in which the HHI is between 1,500 and 2,500 are considered to be moderately concentrated, whereas levels greater than 2,500 are considered to be highly concentrated.[8] The HHI for the dental insurance market in California is 1,813.

What are possible implications of a moderately concentrated dental insurance market? Market concentration could result in higher premiums for consumers or lower reimbursement for providers.[9] More in-depth research is needed, but our preliminary analysis of newly released premiums data indicates that average premiums for most of Delta Dental of California beneficiaries actually decreased from 2014 through 2016 after adjusting for inflation (Table).[6] We do not have access to data for prior years. We also do not have access to data on Delta Dental of California's reimbursement rates to dentists, but a recent lawsuit settlement suggests reimbursement rates have indeed been declining.[10] Moreover, statewide data covering all dental insurers indicate inflation-adjusted reimbursement rates have declined in recent years in California.[11] If more data were publicly available, a more thorough analysis could be conducted. In the meantime, our take on these preliminary data is that market power is being leveraged by insurers primarily to control costs rather than to increase premiums.

Cost control measures, unquestionably, are a good thing for beneficiaries if such measures do not adversely affect access to dentists, quality of care, or benefit levels. Or, more formally, if the adverse effects are outweighed by savings in premiums. Here again we have another important area for further study. The evidence we are aware of—and it is limited—suggests that younger patients are more willing to trade provider choice for savings in premiums than older patients.[12]

Another way to examine the extent to which market power might affect premiums and provider payments is through medical loss ratio (MLR) data. The MLR measures the share of premium revenue that is spent on patient care. The ACA included a provision that MLRs for medical insurers must be at least either 80% or 85%, depending on the type of insurance.

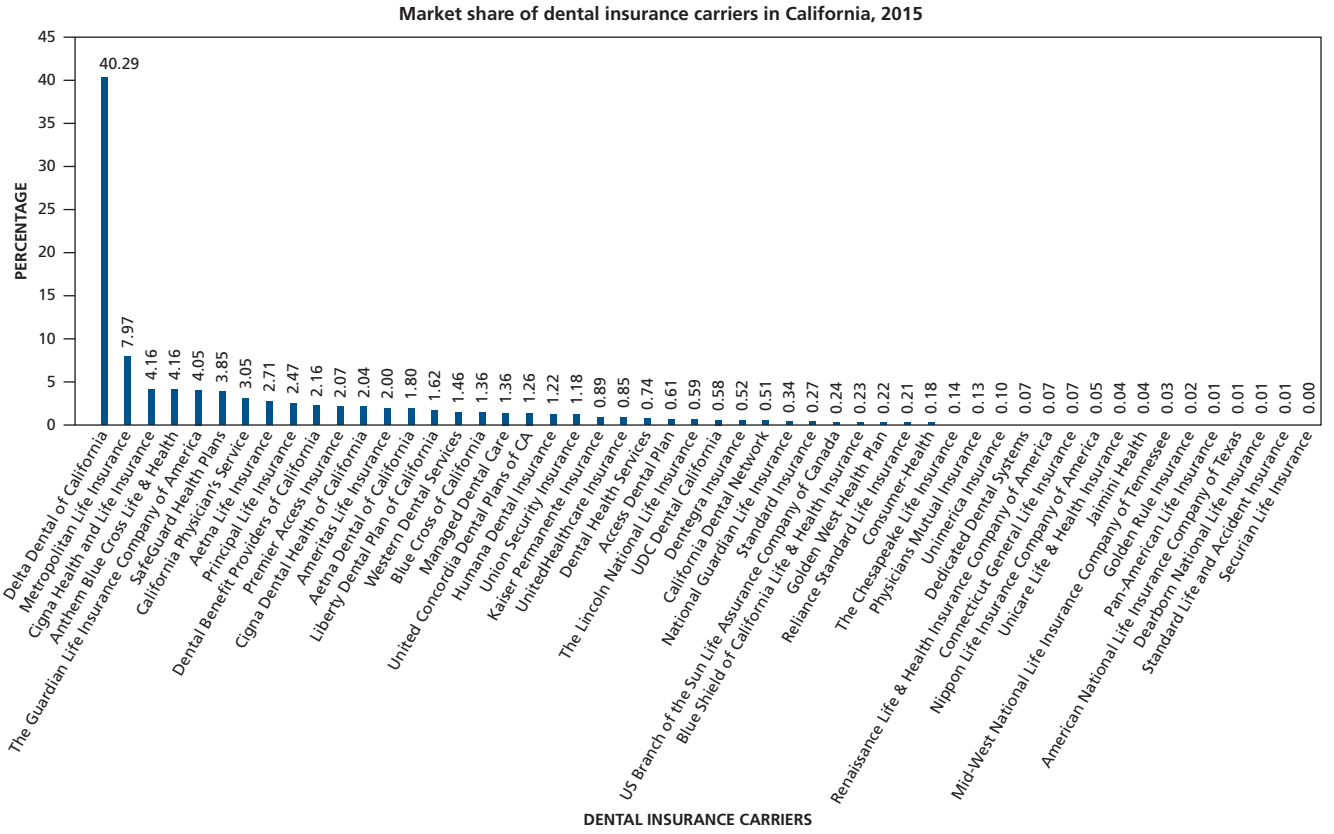



**Figure.** The total number of covered lives in California in 2015 was 9,891,539 (as of March 31, 2016). The number of covered lives were aggregated to the insurer level. The market share of covered lives for each insurer was calculated as the number of covered lives by the insurer in 2015 (as of March 31, 2016) divided by the total number of covered lives in California in 2015 (as of March 31, 2016). *Source: American Dental Association Health Policy Institute analysis of data from California Department of Managed Health Care*[6] *and California Department of Insurance.*[7]

In other words, insurers must spend at least 80% or 85% of total premium revenue on patient care.[13] In 2015, this MLR provision resulted in an average rebate paid by insurers to beneficiaries of $138 per family.[14]

The MLR provision under the ACA does not apply to dental insurers. However, in California, a law was put in place in 2014 to simply collect MLR data on dental insurers.[15] We examined these data and found that among the 52 dental insurers in California, only 6 had MLR levels of at least 80%, including Delta Dental of California, the market share leader. (The dental MLR was calculated as total incurred claims/[total direct premium earned total federal and state taxes and fees to be excluded from premium]. The aggregate percentages at the insurer level were calculated by adding the total incurred claims, total direct premium earned, and total federal and state taxes and fees to be excluded from the premium at the insurer level and then using the aforementioned formulas. The amounts included for this analysis were noted as of March 31, 2016, in the dental MLR reports.) Eight carriers had MLR levels below 50%, meaning less than one-half of premium revenue was spent on patient care. These preliminary data suggest that expanding the ACA's MLR provision to dental insurance could lead to premium reductions or enhanced outlays for dental care, both of which would presumably benefit consumers.

In big picture terms, our analysis of the California dental insurance market indicates a moderate level of concentration by FTC standards, with 1 dominant carrier. We have outlined some potential effects this level of market concentration might have on beneficiaries and providers, based on our interpretation of the data made available so far. Our analysis is based on 1 state and cannot be generalized to other markets. We urge other state agencies to make similar data publicly available. It is encouraging that several states, including Washington,[16] Rhode Island,[17] Illinois,[18] and Massachusetts,[19,20] are proactively pursuing measures to improve data transparency in the dental insurance market. At the national level, we urge organizations such as the National Association of Insurance Commissioners and the National Association of Dental Plans to make data transparency a priority when it comes to dental insurance. This is the only way researchers can study the implications of dental insurance market dynamics. ■

https://doi.org/10.1016/j.adaj.2017.11.016

**Table.** Premiums and covered lives for Delta Dental of California.*

| DENTAL PLAN TYPE | COVERED LIVES IN 2016† | ESTIMATED AVERAGE MONTHLY PREMIUM | | | |
|---|---|---|---|---|---|
| | | 2014 | 2015 | 2016 | Percentage Change (2014-2016) |
| **Large Group DPPO‡** | 2,628,184 (69) | $43.18 | $42.56 | $41.44 | −4.05 |
| **Large Group DHMO§** | 683,667 (18) | $14.64 | $14.40 | $14.00 | −4.34 |
| **Small Group DPPO** | 251,858 (7) | $53.45 | $50.55 | $49.37 | −7.64 |
| **Individual DHMO** | 142,040 (4) | $10.43 | $9.83 | $11.22 | 7.63 |
| **Small Group DHMO** | 76,771 (2) | $18.27 | $17.30 | $16.67 | −8.77 |
| **Individual DPPO** | 10,020 (< 1) | $32.46 | NA¶ | $52.84 | 62.82 |

*The average monthly premium was calculated as the total direct premiums earned (as of March 31 of the next year) divided by the number of member months (as of March 31 of the next year). All amounts are adjusted to 2016 dollars using the Consumer Price Index for Dental Services. Premium data for individual DPPO plans were unavailable for 2015. The percentage of covered lives for each plan is the number of covered lives for that plan divided by the total number of covered lives by Delta Dental of California in 2016. *Source: American Dental Association Health Policy Institute analysis of data from California Department of Managed Health Care.*[6]; †Values are n (%); ‡DPPO: Dental preferred provider organization; §DHMO: Dental health maintenance organization; ¶NA: Not applicable.

Dr. Vujicic is the chief economist and the vice president, Health Policy Institute, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611, e-mail vujicicm@ada.org. Address correspondence to Dr. Vujicic.

Dr. Gupta is a health services researcher, Health Policy Institute, American Dental Association, Chicago, IL.

Dr. Nasseh is a health economist, Health Policy Institute, American Dental Association, Chicago, IL.

This column represents the opinions of the author and not necessarily those of the American Dental Association.

**Disclosure.** The authors did not report any disclosures.

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North Dakota
DENTAL ASSOCIATION

# VOTE YES

# ON HB 1481

- Ensures Value for Dental Insurance Purchased by Employers
- Protects Employers and Consumers From Large Dental Insurance Premium Increases
- Protects Patients from Conflicting and Burdensome Administrative Practices and Claims Practices by Dental Insurance Companies
- Incentivizes Utilization of Dental Insurance Leading to Better Oral Health and Overall Health of North Dakotans
- Improves the Reputation, Image, Perception and Value of Dental Insurance
- Aligns the Interests of Dental Insurance Companies with the Oral Health of Consumers
- Places Patients Care over Insurance Company Profits

North Dakota DENTAL ASSOCIATION

# Dental MLR – Responding to Opposition "Claims"

**THE CLAIM**
Dental insurers claims that providers are "against" administrative costs.

**THE TRUTH**
Dentists support "patient-centered" administrative costs and necessary money spent to provide high quality dental plans – MLR merely provides real incentive for dental insurers to become more efficient.

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**THE CLAIM**
Insured patients currently have excellent access to dental care.

**THE TRUTH**
Many patients struggle to afford dental care, even with insurance.

- ADA member dentists regularly see patients who are unable to afford their dental care despite having insurance.
- Insurance companies earn more money when they deny care. There is currently no disincentive to refuse to pay for care.
- Most dental plans currently have an annual maximum benefit that is insufficient to cover major unforeseen dental care needs, leaving patients to bear the costs.

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**THE CLAIM**
Dental insurance is different from medical insurance, with slimmer profit margins, and can't meet the same standards.

**THE TRUTH**
Dental carriers are making plenty of profit and their CEOs earn millions every year. They shouldn't be doing so on the backs of dental patients.

- The principles of transparency, value and access to care are the same for dental insurance as they are for medical insurance. Regardless of the type of healthcare, patients deserve to know that the premiums they or their employer are paying are being spent on actual care.
- We would gladly support additional policies to improve dental insurance for patients.
- In the meantime, this is a sensible policy that would improve value and access for dental patients.

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**THE CLAIM**
A large portion of dental premiums go to administrative costs, which is good for patients.

**THE TRUTH**
A large portion of dental premiums go to administrative costs, which takes away from patient care.

- Delta's data confirms what we already knew: In some plans, nearly half of premium dollars are spent on non-patient care expenses.
- Excessive spending on executive salaries and corporate profits does not support patients.
- Delta is selectively sharing information about individual and small group plans. Most insured patients are covered by large group plans, where the overhead costs can be much lower – if the insurance carrier is motivated to hold them down.

- Insurers will be held accountable to a fair MLR across all lines of business. Focusing only on individual and small group plans is misleading.
- We know dental insurers can meet the proposed MLR standard because many already do. MLR legislation would bring the others in line.

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**THE CLAIM**

"Rebates are self-defeating and cost too much to generate."

**THE TRUTH**

Experience with MLR rebates for medical insurance demonstrate that rebates can be efficiently issued.

- For most plans, employers are paying most of their employees' premiums. Issuing rebates does not require a multitude of checks to individual members on those plans. It requires larger, consolidated rebates issued to employers.
- Many, if not most, rebates will be issued as discounts or credits on insurance premiums, eliminating the need to mail checks.
- The primary purpose of MLR laws is not to force companies to issue rebates. Rather, the goal is to incentivize companies to pay for needed patient care.

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**THE CLAIM**

To adjust to MLR laws, dental insurers will be forced to reduce or eliminate plans offered, or raise premiums, leading to poorer care for consumers.

**THE TRUTH**

If dental insurers leave states with MLR laws or raise patient premiums, they are making a choice to do so.

- Medical insurers made these claims when Congress was debating the Affordable Care Act. However, they have remained profitable and competitive.
- Many dental insurers already meet the proposed MLRs, demonstrating that it is possible to be both compliant and profitable.
- Dental insurers' threats to raise premiums rather than control administrative spending demonstrates clearly that insurers prioritize profits over oral healthcare.
- We can include language in the model that requires state approval for the insurers to raise premiums above a certain level (e.g., beyond dental services' consumer price index).

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# Ensuring Value for Patients in Dental Insurance

North Dakota DENTAL ASSOCIATION

**Patient dollars should be spent on patient care, not on the profits of big dental insurance companies and their executives. North Dakota should ensure patients get the value they deserve for the dental insurance premiums they pay.**

## Patient Concerns

For too long, multibillion-dollar dental insurance companies have taken advantage of the lack of accountability for how patient premium dollars are used.

The limited available data indicates that around 40% of dental premium dollars are used by insurance companies to cover administrative costs, profits and executive compensation, instead of being directed toward patient care.

Medical Loss Ratio, or MLR, is the portion of insurance premiums that is spent on patient care, rather than insurer overhead costs. All states have laws requiring medical insurance to maintain a minimum MLR, but very few have a similar standard for dental insurance plans.

## Solution

**Patient dollars should go to patient care.**

The North Dakota Dental Association is advocating for legislation requiring that at least 83% of dental insurance premiums be spent on patient care. If insurers fail to meet this standard, they would be required to refund the difference to covered individuals and groups, which is a similar requirement for many major medical plans.

Requiring a higher portion of premium dollars to be spent on patient care can help reduce out-of-pocket costs for patients, making dental care more affordable and encouraging people to go to the dentist.

This policy is popular across the political spectrum: In 2022, 72% of Massachusetts voters approved a similar bill at the ballot box.

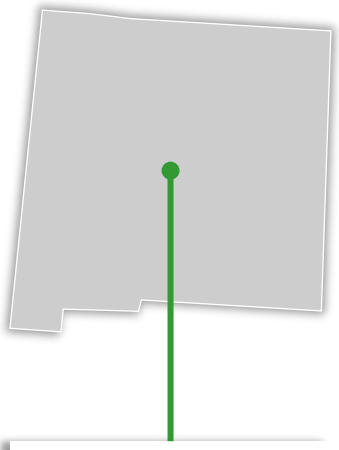
## What Are the Benefits of Medical Loss Ratio (MLR) Laws?

- Patients and employers who pay insurance premiums are guaranteed a good value for their money.
- Dental insurers cannot simply raise premiums without investing the new money in patient benefits.
- Rebate requirements incentivize insurers to meet the threshold and return money to patients and employers if they are overcharged for their premiums.

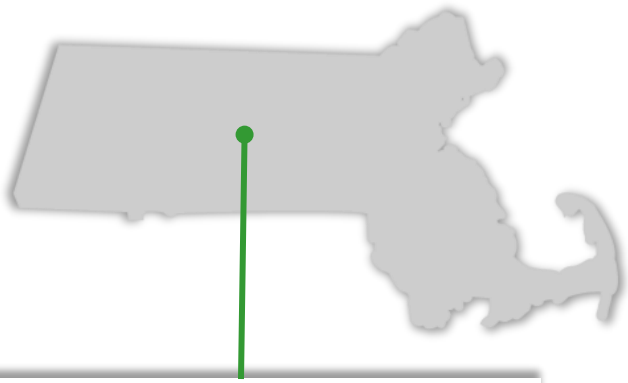
**To learn more about medical loss ratio legislation in North Dakota,**
please contact the North Dakota Dental Association
at 701-223-8870 or William Sherwin at wsherwin@smilenorthdakota.org.

North Dakota DENTAL ASSOCIATION

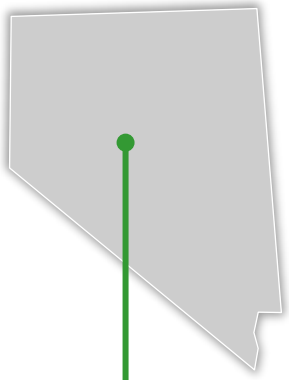
# Medical Loss Ratio Legislation is Gaining Momentum



**New Mexico: 2022**
Dental insurers' plans & coverage must be rejected as unreasonable if they do not meet 65% MLR.



In 2022, **72% of Massachusetts** voters passed **Question 2,** requiring dental insurers to spend at least 83% of premiums on patient care – or refund consumers. Question 2 received more votes than any party's nominee for governor, demonstrating broad bipartisan support.



**Nevada: 2023**
Dental plans are prohibited from selling at an "excessive rate" with MLR under 75%. Commissioner may order insurers to compensate insured affected by excessive rates.

"*Adding a requirement for a medical loss ratio for dental insurance would help promote price transparency and provide incentives to reduce administrative waste. This would help reduce costs for patients*."

Consumer Choice Center,
Policy Note: Dental Insurance Reform

*"It doesn't take much to see how poorly dental insurers are serving people under the current system. More than half of Americans delay getting medical care — or avoid it altogether — because of burdensome costs, and the most frequently skipped form of care is dental … This needs to change, and passing [Question 2] is the first step."*

*Boston Globe,*
Vote Yes on Question 2

*Note: Several other states have passed laws requiring dental insurers to* report *their medical loss ratios. While these laws are a step in the right direction, dental patients need and deserve laws that set a minimum standard for dental MLR.*

**To learn more about medical loss ratio legislation in North Dakota,** please contact the North Dakota Dental Association at 701-223-8870 or William Sherwin at wsherwin@smilenorthdakota.org.

Madam Chair Lee, Vice Chairman Weston and honorable members of the Senate Human Services Committee,

**Dental Premiums Should be Spent on Patient Dental Care**

It seems intuitive that dental insurers would spend a large majority of the money they collect in premiums on patient dental care. However, that is not always the case. North Dakota lawmakers can — and should — fix this problem this legislative session.

Lawmakers can protect North Dakota dental patients by passing legislation requiring that dental insurers **spend at least 83%** of patient premiums on patient care or refund the difference to patients. This law, known as Medical Loss Ratio, would increase transparency in dental insurance and help keep both premiums and out-of-pocket costs manageable for patients. Health insurance carriers in North Dakota are already required to adhere to these standards, but no standard such as this, exists for dental insurance.

There are many ways to make dental insurance work better for patients, so they do not delay or avoid needed care. Simply requiring dental insurers to spend the money they collect in premiums on patient care may be one of the most powerful.

Available data indicates that 25% or more of dental premium dollars are used by insurance companies to cover administrative costs, profits, and executive compensation, instead of being directed to patient care. When every dollar that is shifted away from providing care ends up boosting dental insurers' profits, they have a powerful incentive to spend as little as possible on patient care. A law requiring them to spend at least 83% of premium dollars on patient care will fix that problem.

Dental insurers may claim that they cannot meet this reasonable standard, and that as a result, they will be forced out of business in our state. Patients in North Dakota should not be fooled by this argument. Health insurers have **remained profitable** under similar standards, and they continue to increase their net income. In addition, some dental insurers already meet this standard. We need a law to bring the others in line.

Skipping dental care can have serious consequences, not just for oral health but for overall health and wellbeing. Poor oral health is linked to conditions such as strokes, as well as poorer academic and employment outcomes. For these reasons and more, we must minimize cost barriers between patients and care.

Patients already know their dental insurance is not serving them well, which is why a bipartisan 72% of Massachusetts voters elected to adopt this policy a couple years ago. North Dakota dental patients deserve the same protections. Our lawmakers have the power to make it happen, and they should do so without delay.

Respectfully,
Kami Dornfeld DDS
Williston, ND
NDMOM Chair
Medicaid Provider

**Patient Dental Insurance Dollars Should Be Spent on Patient Care**

Patients who pay monthly premiums for dental insurance expect insurance to pay for their dental care. As a dentist, unfortunately, I have seen that this is not always the case, causing major problems for patients. **The State Legislature can provide a solution by requiring that at 83% of patients' dental insurance premium dollars are spent on patient dental care.**

I have this discussion far too often with many of my patients. Once treatment options have been viewed and determined for the patient's best interest, they bring up the same question. "How much will my insurance cover?." It is a very difficult discussion to have. All this money spent for dental coverage, yet very little is paid by the insurance company toward treatment. This situation, unfortunately, leads to delayed treatment, or sometimes, no treatment at all.

This problem isn't unique to my patients, or patients in North Dakota. Nearly half of American adults

say they find it difficult to afford healthcare costs. They also say they are more likely to put off oral healthcare than any other type of care. When patients can not get the dental treatments they need, oral health problems can get much worse, leading to more extensive and expensive treatment down the road. Research has also shown that poor dental health is linked to conditions such as strokes and academic and employment challenges. Sadly, I see these real-life consequences in my practice.

According to available data, a quarter of dental premiums are currently being spent by insurance companies on things like executive salaries, administrative costs and boosting profits — none of which directly benefit patients. Some insurers spend far more. While highly paid executives and shareholders reap the benefits, patients pay the price.

The State legislature can help protect dental patients by requiring that dental insurers spend at least 83% of the premiums they collect on patient care. If insurers do not meet this standard, they must refund the difference to patients or, if an employer is paying the premiums, to the employer. This law, known as Medical Loss Ratio, would increase transparency in dental insurance and help keep both premiums and out-of-pocket costs more manageable for patients.

It is also a tried-and-true strategy. **Medical insurance carriers in Our State are already required to adhere to such standards, but currently, North Dakota does not apply the same standard to**

**dental insurance.**

While dental insurers may say this is an unreasonable standard that will force them to stop selling insurance in North Dakota, we know this is simply untrue. Health insurers remain profitable under similar standards, and have in fact continued to increase their net income.

Some dental insurers already meet the 85% standard, but with no transparency and no minimum standard, some fall short. It is time to pass a law to ensure all patients get good value for the premiums they pay.

Dental patients know their dental insurance is not serving them well. That is why 72% of Massachusetts voters from across the political spectrum voted to adopt Medical Loss Ratio for dental insurance in November. North Dakota patients deserve the same protections.

Our lawmakers have the power to make it happen, and they should do so without delay this year.

Thank you for your support in HB1481,

Tessa Lagein DDS,

Valley City ND

Medicaid Provider

**Testimony in SUPPORT of HB 1481, Dental Loss Ratio**

Chairman Warrey and Members of the House Industry Business and Labor Committee:

My name is Pete Mecham. I am an endodontist in Grand Forks, where I have been in practice for 10 years. I am here today to testify in support of **HB 1481, Dental Loss Ratio**.

My patients come to me for root canals and root end surgeries (apicoectomies). One of the most frustrating things I encounter is when a patient needs care — sometimes urgently — and cannot afford it. This does not just happen with patients who are uninsured. It happens with alarming frequency to patients insured by companies that have found a way to decline to pay for their care.

Data shows that 25% or more of patient premium dollars for dental care are not actually spent on patient care. Instead, they are used for administrative expenses like high executive salaries and shareholder dividends. It's time for that to change.

The Affordable Care Act (ACA) requires medical insurance companies to spend a minimum percentage of premiums on patient care, but our state has no such policy for dental insurers. It is time for that to change.

HB 1481 would require that dental insurers spend at least 83% of patient premiums on patient care. If they fall short, they would have to send rebates to the patients and employers that paid the premiums. This would be a powerful measure to incentivize insurers to pay for more patient care — and it represents an important patient protection measure that will strengthen dental insurance for all.

I ask you to please support North Dakota dental patients by advancing HB 1481.

Pete J. Mecham, DMD, MS

**Testimony in SUPPORT of HB 1481**

Madam Chair Lee and Members of the Senate Human Services Committee:

My name is David Duevel. I am an orthodontist in Fargo, where I practice clinical orthodontics and run my own small business. I am here today to testify in support of HB 1481.

Data shows that 25% or more of patient premium dollars for dental care are not actually spent on patient care. Instead, they are used for administrative expenses like high executive salaries and shareholder dividends. It's time for that to change.

The Affordable Care Act (ACA) requires medical insurance companies to spend a minimum percentage of premiums on patient care, but our state has no such policy for dental insurers. It is time for that to change.

HB 1481 would require that dental insurers spend **at least 83%** of patient premiums on patient care. If they fall short, they will have to send rebates to the patients and employers that paid the premiums. This would be a powerful measure to incentivize insurers to pay for more patient care — and it represents an important patient protection measure that will strengthen dental insurance for all.

Other states, such as Nebraska, have similar measure up for vote. I surmise that most states will eventually adopt such statutes, and I hope that our state will be a leader in legislation of this type!

I ask you to please support North Dakota dental patients by advancing HB 1481.

Thank you for all that you do to serve the residents of our great state!

David Duevel, DDS, MS

Fargo Orthodontics

Fargo, ND

North Dakota
DENTAL ASSOCIATION

Physical Address: 1720 Burnt Boat Drive, Suite 201
Mailing Address: PO Box 1332, Bismarck ND 58502
T: 701-223-8870

March 10, 2025

Regarding: HB 1481

Madam Chair Lee and Members of the Senate Human Services Committee;

On behalf of the North Dakota Dental Association, our Board of Trustees, over 400 member dentists, and over 500,000 North Dakotans we treat; I would humbly ask for your support of our NDDA DLR Bill HB 1481. As your clinically trained and licensed dental professionals in our state, we are responsible for the oral health treatment and outcomes of the citizens across our state. HB 1481 is one of many initiatives we take up on behalf of our patients to make dental care more affordable, accessible and valuable.

Oral health is a vital component of overall health and often overlooked or brushed aside by our society. There are many barriers to care that our patients(your constituents) face and the number one identified barrier is "cost." As an industry and profession, we take our Hippocratic oath to serve the members of our community, and a foundational component of that oath is provision and access to our dental care services. Along with providing an adequate network of providers for our public assistance system(Medicaid), for our underserved communities, we also are focused on affordability and value for consumers in the private market. With "cost" being the number one concern and barrier for consumers, HB 1481 works directly to drive value and utilization into the insurance products that many of our patients have, but often struggle to understand and utilize.

Dental Insurance has been cumbersome and problematic(for decades) for not only us as providers(the sophisticated entities in our space), but more importantly and problematically our patients. Dental is different. We embrace that, understand that, but also work hard to educate and empower our patients to engage and interact with a system that is nuanced, different and separated from Major Medical Systems. Our distinction brings you the personalized service, small town community and main street business delivery of care, but also carry's the burden that is compliance with today's dental insurance industry and coverage.

Our members across the state continue to do what they feel is best for North Dakota and are focused on that, taking care of North Dakota. HB 1481 is one small step in the right direction. Just as we challenge the dental insurance to do better and be better, we constantly challenge ourselves and our members to do better and be better by our fellow neighbors. There is always more to do and always more that can be done. I hope you come visit one of our future Mission of Mercy's where we transform a public site into a free dental clinic treating over a 1,000 North Dakotans across two days or come to our NDDA Medicaid Dental Medicaid Advisory Workgroup Meetings to join in the work being done to drive access for our underserved communities in our state.

We stand with you, alongside you, ready to treat, take care of and stand up for the oral health needs of the citizens of our state. Please stand with us on HB 1481.

Respectfully,

Dr. Walter Samuel

Dr. Walter Samuel
President North Dakota Dental Association

March 10, 2025

**RE: House Bill 1481 – OPPOSE**

Dear Chairman Lee and committee members,

On behalf of the American Council of Life Insurers (ACLI)[1], we appreciate the opportunity to provide comments in opposition to House Bill 1481. As introduced, this bill would create a dental minimum loss ratio (MLR) of 75 percent for dental benefit plans. This bill would create unintended consequences that severely impact access to dental care and benefits for North Dakotans. It would lead to increased premiums, reduced use and access to dental services, and a reduction in employer and consumer options for purchasing dental coverage.

**Dental Plans Differ from Medical Plans**

Dental plans offer a wide variety of products and benefit designs compared with medical plans. Any measurement of a dental plan's value must reflect the fundamental differences between how medical and dental plans are structured, priced, offered, and purchased if it is to be accurate and meaningful to consumers.

Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventive services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Consumers share a higher percentage of the cost for restorative procedures such as crowns, periodontal surgery, and dentures. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5 percent.

In North Dakota, dental premiums are on average, about $33 per month[2] and medical premiums are, on average, about $708 per month.[3] At a 75 percent loss ratio, this leaves medical plans with over $175 to cover administrative expenses per member per month. At a 75 percent loss ratio, dental plans would be left with less than $9 to cover administrative expenses per member per month. This small amount would not cover the cost of basic plan operations for even the most cost-efficient plans: administration; claims systems; compliance; and state-mandated consumer protections and commissions. If low-cost plans

[1] ACLI is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long- term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] NADP, 2024. Dental Benefits Report. (link)

[3] "Average Annual Singel Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation (2023). Employers typically contribute about $613 per month while employees typically contribute about $95 per month.

cannot cover their administrative expenses under the 75 percent loss ratio, those plans may be forced to no longer offer in North Dakota or to raise premiums to cover increased costs.

In Massachusetts, the only state to adopt a similar, mandatory dental loss ratio (through ballot initiative), the market for dental insurance has contracted significantly, with at least 7 fewer carriers in the small group and individual markets, a 32 percent decline, since the imposition of the DLR in 2022. An independent analysis of similar bills indicates that a mandated dental loss ratio of 75 percent could raise premiums for dental coverage by 114 percent for small groups, and 78 percent for the individual market.[4] The analysis highlighted the risk that such a sudden and rapid increase in the cost of coverage will lead many small businesses to forgo dental plans for their employees and reduce access to oral health care.

**Dental Plans and Oral Health**

House Bill 1481 has the potential to dramatically reduce the availability of dental coverage in North Dakota with negative effects on access to oral health care. Dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Under a typical dental plan, preventive care is covered at 100 percent cost sharing to incentivize utilization and a regular relationship with a dentist. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

Dental insurance has been shown to be highly price sensitive and an increase in premiums may lead to a reduction in dental coverage. Losing coverage often means patients must pay full list price for their dental care and a cleaning may cost hundreds of dollars out of pocket. As a result, many people without dental coverage skip regular preventive services to reduce costs and in the long term this increases their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions. For these reasons, we oppose House Bill 1481 and urge you not to advance the legislation.

**National Council of Insurance Legislators ("NCOIL") Model**

In 2023, NCOIL adopted the Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act ("NCOIL Model") that would promote transparency and protect the current dental insurance market. The Model Act is a result of a compromise between the American Dental Association and the National Association of Dental Plans. The NCOIL Model would achieve the goals of House Bill 1481 without the unintended consequences of higher costs to consumers and market constriction.

The NCOIL Model requires dental insurers to report MLRs to the Department of Insurance. The commissioner would then calculate an average for each market segment: individual, small group, and large group and investigate any insurers who fall far enough outside the average. Commissioners would have authority to remediate the insurers where appropriate and potentially establish an MLR based on the average if an insurer falls outside the average for two consecutive years. It would also allow flexibility for the experts at the Department of Insurance to determine if there is a legitimate reason that the MLR is low, for example a plan in its first year that must build up reserves.

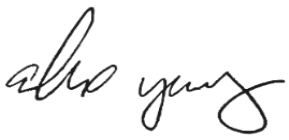
[4] AB 2028 Medical Loss Ratios Report final to Legislature 04122024.pdf

Enacting the NCOIL Model would allow the commissioner to set an MLR appropriate for the market when a plan falls outside the market average for two consecutive years. This approach protects consumers by preventing the market disruption we are seeing in Massachusetts. Rather than setting an arbitrary number across all market segments without fully assessing what the market can withstand, the NCOIL Model relies on the expertise of the Department of Insurance to assess the market and intervene where appropriate.

Under the NCOIL Model, insurers would be held to greater standards of transparency and would be held accountable for inappropriately low MLRs. However, there is unlikely to be the rise in costs we would see if insurers had to meet a 75 percent MLR that is too high for the market to support. Consumers would benefit from the transparency and accountability, but would not be subject to rising costs and less choice in plans.

Thank you for your consideration. We look forward to working with you to develop this alternative avenue to evaluate the value of dental benefits in North Dakota.

Respectfully submitted,



Alex Young
Legislative Director, State Relations
ACLI

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine



**National Council of Insurance Legislators (NCOIL)**

# Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act

***Sponsored by Del. Steve Westfall (WV)***
***Co-sponsored by Rep. Rita Mayfield (IL)***

***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on January 26, 2024. To be placed on the Executive Committee's agenda for final ratification at the 2024 NCOIL Spring Meeting on April 14, 2024.***

**Table of Contents**



## Section 1. Title

This Act shall be known and cited as the "[State] Medical Loss Ratios for Dental (DLR) Health Care Services Plans Act."

## Section 2. Purpose

The purpose of this Act is to 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.

## Section 3. Definitions

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Dental carrier" or "carrier" means 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.

(c) "Dental health care service plan" or "plan" means any plan that provides coverage for dental health care services to enrollees in exchange for premiums, and does not include plans under Medicaid or CHIP.

(d) "Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated pursuant to subsection (i) in this section.

(i) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

(A) 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 at 45 CFR 158.140(a); and

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

(1)(a) The Commissioner shall define by rule:

(I) expenditures for clinical dental services;

(II) activities that improve dental care quality;

1. Activities conducted by an issuer intended to improve dental care quality shall not exceed five percent of net premium revenue

(III) overhead and administrative cost expenditures; and

(ii) 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 carriers offering health benefit plans in the state. Overhead and administrative costs must not be included in the numerator.

**Section 4. Transparency of Patient Premium Expenditures**

(a) A carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Dental Loss Ratio (DLR) 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). The filing must also report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

(b) The DLR reporting year shall be for the fiscal year during which dental coverage is provided by the plan. All terms used in the DLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If data verification of the carrier's representations in the DLR annual report is deemed necessary, the commissioner shall provide the carrier with a notification 30 days to submit any information required by the Commissioner.

(d) By January 1 of the year after the Commissioner receives the dental loss ratio information collected pursuant to subsection (a) of this Section, 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 carriers by plan type by:

(i) Posting the information on the division's website; or

(ii) Providing the information to the administrator of an all-payer health claims database. If the Commissioner provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the Commissioner.

(e) The Commissioner shall report the data in this Section to the Legislature.

**Section 5. Excess Revenue and Rebate**

(a) The Commissioner shall aggregate dental loss ratios for each carrier by year pursuant to Section 4 for each market segment in which the carrier 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.

(1) Newer experience shall be subject to reporting standards at 45 CFR 158.121

(b) The Commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection 5(a), identify as outliers dental plans that fall outside 1 standard deviations of the average dental loss ratio, and report those plans to the legislature consistent with the manner set forth in subsections 4(e) and 4(d) above.

(1) A carrier shall not be considered an outlier if its DLR 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.

(c) The Commissioner shall investigate those carriers that report a DLR lower than 1 standard deviations from the mathematical average, and may take remediation or enforcement actions against them, including ordering such carriers to rebate, in a manner consistent with 45 C.F.R. Part 158(B) of the ACA all premiums paid above such amounts that would have caused said carrier to have achieved the mathematical average of the data submitted in a given year for a given market segment.

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

(e) A carrier subject to remediation in subsections (c) and (d) shall provide any rebate owing to a policyholder no later than xxxxx of the fiscal year following the year for which the ratio described in subsection (a) of this section was calculated. The Commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

(f) The Commissioner may promulgate rules that create a process to identify carriers that increase rates in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.

**Section 6. Rules**

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act.

**Section 7. Effective Date**

This Act shall take effect xxxxxxx.

Government Relations

Principal Financial Group®
711 High Street, Des Moines, IA 50392-0220
D 515.247.5111 / F 855.822.6071
www.principal.com

March 10, 2025

RE: House Bill 1481 – OPPOSE

Dear Chair Lee and Members of the Committee,

Principal Financial Group ("Principal") appreciates the opportunity to provide comments in opposition to HB 1481. Principal provides dental coverage to 164 small and medium sized businesses and over 4,100 members in North Dakota. As explained below, Principal opposes HB 1481 because it is likely to destabilize the dental market and limit the options available to consumers.

House Bill 1481 proposes to establish a minimum loss ratio of 75% for dental plans. While such a standard might work for medical insurance, it does not work for a lower cost product like dental insurance. As a percentage of premium, administrative costs are much higher for dental insurance than they are for medical insurance. The reason is that dental premiums are a fraction of what a typical medical premium might cost. The cost of administration, however, is much more even. Imposition of a 75% minimum loss ratio for dental plans simply does not leave enough premium dollars to pay for administration, claims systems and compliance costs, whereas a similar loss ratio for medical insurance leaves many more dollars to pay for these expenses.

These problems are further exacerbated when applied to dental plans offered to small groups. Administration costs as a percentage of premium are higher for small groups than large groups because the costs of onboarding the group and other administrative expenses are incurred more frequently to service the same number of members. Stated another way, it is more expensive to administer 10 groups of 10 employees than one group of 100 employees. As an insurer focused on the small and medium size business market, Principal is particularly impacted by imposition of a minimum dental loss ratio.

As you may be aware, Massachusetts recently passed a ballot measure imposing an 83% minimum dental loss ratio on dental plans. After evaluating the impact of the measure Principal was forced to announce it was exiting the dental market for small businesses with under 25 employees. After careful analysis, Principal determined that we were unable to maintain the level of services that our customers expect while continuing to provide affordable coverage. Faced with either raising premiums or reducing our level of service, Principal decided it did not like either of those options and elected instead to leave the under 25 dental market in Massachusetts effective November 1, 2023.

Should HB 1481 become law in North Dakota, Principal and other dental insurers, particularly those in the small and medium size business dental market, will be forced to make similar decisions. We do not believe that to be in the best interest of North Dakota dental consumers. This legislation is simply not necessary, and we believe it will be harmful to our members. This Committee should reject HB 1481.

Respectfully submitted,

**James M. Harrison**
Director and Counsel, State Government Relations
Principal Financial Group

JMH:bkl…box\staff\bkl\jmh\l031025jl

FIRST OPINION

# ‘Rationing by inconvenience’: Health insurers count on customers not appealing denials

For many patients, the appeal process is just too much


Adobe

**By Miranda Yaver** Jan. 23, 2025

Yaver is an assistant professor of health policy and management at the University of Pittsburgh.

When Jessica (not her real name) learned in her 20s that she had severe immunodeficiency, she was prescribed subcutaneous immunoglobulin therapy (SCIg), a very expensive type of injection treatment that can protect against infection and prevent long-term damage from infections. She had no idea the challenges that would lie ahead when her physician submitted the request for prior authorization, or pre-approval from her private insurer.

The prior authorization was denied. What's more, in an unusual move, the insurer declined to allow a "peer-to-peer" review of her case between her physician and one working for her insurer.

As she told me when I interviewed her for my research, the denial was puzzling because the treatment was not experimental or investigational for her condition. Indeed, it was for on-label use. Then she read the fine print: She was denied because her infections were not yet life-threatening. *Did they also wait for diabetics to have life-threatening glucose levels before approving treatments?* she pondered.

While she appealed and coordinated with her physician's and specialty pharmacy's offices, she continued to acquire infections that necessitated several courses of antibiotics, exposing her to the possibility of antibiotic resistance. She was worn down. She considered it a matter of luck that she was not hospitalized. In an act of desperation, she reached out to the office of Sen. Bill Cassidy (R-La.), a physician and one of her state's senators, not expecting much to come of it.

But she was in luck. Soon after contacting them, the office contacted her insurer, which approved the drug.

Most Americans can relate to Jessica's experience of going to the pharmacy expecting to pick up a prescribed medication, only to learn that it was delayed because the insurer had not yet approved it. Or perhaps trying to get a scan to identify the cause of pain. Or a non-emergent surgery.

Largely an artifact of managed care plans guarding against overutilization of health care and excessive health care costs, most plans utilize prior authorization, especially for higher-cost tests and treatments. In fact, there are 182 million prior authorization requests

per year in the medical commercial market alone. And in stark contrast with traditional Medicare, 99% of Medicare Advantage enrollees are in plans that have prior authorization requirements, with Medicare Advantage plans alone submitting over 46 million prior authorization requests in 2022.

Though most prior authorizations are approved, 36% of the 1,340 people who responded to my nationwide survey experienced at least one initial denial (usually multiple denials). As Jessica's story highlights, the effects can be devastating both medically and psychologically. In fact, a 2023 Department of Health and Human Services Office of the Inspector General report found high rates of wrongful denial by Medicaid managed care plans, which serve primarily low-income patients. These denials are disruptive not only because of delays, but because of the ensuing confusion and frustration of learning how to be an effective self-advocate.

What's more, that confusion and frustration might be intentional.

A physician employed by the health insurance company Elevance once told me, "We have productivity metrics. We probably have 10 or 15 minutes or so to do reviews and depending on the case, that may not be adequate. And we're told denying things is OK because people can appeal." The problem is that these appeals impose substantial costs on patients, many of whom don't ultimately get their prescribed treatments. While Jessica persisted in her appeal, others do not.

I characterize this dynamic as "rationing by inconvenience." The appeal process's administrative burdens — to draw on the language of Pamela Herd and Donald Moynihan's seminal work on this subject — lead far too many Americans to go without prescribed care not due to *final* denial, but rather because of accumulations of inconveniences and psychological toll leading people to abandon the appeal process. It may even make them more reluctant to seek future treatment.

Herd and Moynihan conceptualize administrative burden as being comprised of three components: learning costs (learning about a program and how to navigate its complexities), compliance costs (the documentation and time costs associated with following administrative rules), and psychological costs (the emotional toll and experience of loss of autonomy). While administrative burdens are typically discussed in the context

of public programs (such as Medicaid and SNAP), this framework can be extended to patients' navigation of the increasingly privatized health insurance setting, which is laden with prior authorizations that induce delays and denials of coverage.

These administrative burdens are quite impactful. Despite appeal processes being in place, researchers at the Kaiser Family Foundation have found when looking at ACA marketplace plans that fewer than 1% of denied claims are appealed.

When examining appeal processes of health insurers, it's little wonder why so many people opt out of appealing. Some UnitedHealthcare plans have appeal packets as long as 14 single-spaced pages, detailing three levels of standard and three levels of expedited appeals. And if the patient is not in a life-threatening situation, the standard appeal can take quite some time: The insurer has 30 days to respond to the initial appeal and 15 days to respond to an internal appeal. It may take up to 26 days to receive the determination from an independent medical review.

In the meantime, the patient may be left untreated or receiving suboptimal treatment because they do not know or have the energy to navigate these barriers to health insurance coverage and, in turn, care.

That Jessica struggled to learn the rationale for her denial and how to reverse it is perhaps unsurprising to anyone who has spent hours on hold with their insurer or pored through complex insurance documents. In fact, while the average U.S. adult reads at the seventh to eighth grade level, health care materials are typically written at the 10th grade level or higher, despite recommendations that they be written at the fifth or sixth grade level to promote accessibility.

The readability of health insurance materials is important because health literacy, or the ability to obtain and understand health information, is not evenly distributed across the population. The National Assessment of Adult Literacy Survey found that not only do 36% of Americans have basic or below basic health literacy, but several groups fare worse: people who are elderly, non-native English speakers, or not white, and those who have low socioeconomic status and/or educational attainment.

This dynamic exacerbates the administrative burdens associated with challenging health insurers' denials of coverage, and contributes to my finding that the most common reason

why patients opted out of appeal was they did not understand that it was an option available to them. What's more, people typically underestimate patient chances in appealing decisions by health care giants like UnitedHealthcare or Cigna when, in truth, patients win about half of the time.

When advantages such as race, education, and income are so pivotal in being able to successfully navigate the American health insurance system, it is little wonder why the American health care system produces such pronounced health and health care disparities along race and class lines.

Jessica is white. She is college-educated. She has consistent employment (connected to the insurance industry, in fact, though not health insurance). And she still struggled. But she did appeal, and many from less advantaged positions do not.

Consistent with prior arguments that administrative burden is a mechanism of inequality, I found in my survey that less affluent patients are less likely to appeal coverage denials, as are those respondents who estimate that patients rarely win appeals. That is, they are less likely to see the value in navigating these administrative barriers, which come with opportunity costs of time, energy, and potentially money.

What's more, Black or Hispanic Medicaid enrollees who responded to my survey were substantially less likely than other Medicaid enrollees to prevail when they did overcome these challenges. And in a country with notably expensive medical care, these decisions to forego appealing leads to high rates of health care postponement, especially among these marginalized groups.

The recent shooting of UnitedHealth CEO Brian Thompson laid bare on social media the widespread patient anger and frustrations that define the uniquely American experience of navigating the health insurance system, which is rife with red tape and resulting inconveniences and inequities.

Though some prominent insurers like UnitedHealthcare and Cigna have scaled back some of their reliance on prior authorization, the new Trump administration is likely to accelerate America's already growing reliance on Medicare Advantage and its associated prior authorizations and administrative burdens.

Political scientist David Mayhew famously declared members of Congress to be “single-minded seekers of re-election,” and constituency service is thus vital toward this end. Nevertheless, few patients know as Jessica did that enlisting elected officials is a path to remedying health insurance barriers. She couldn’t help but wonder: Why did it have to come to that?

*Miranda Yaver, Ph.D., is an assistant professor of health policy and management at the University of Pittsburgh, where she also holds a secondary appointment in the department of political science.*

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**Letter to the editor**

Have an opinion on this essay? Submit a letter to the editor.

# Senate report slams Medicare Advantage insurers for using predictive technology to deny claims

UnitedHealth, CVS and Humana used technology to increase MA prior authorization denials for post-acute services, boosting profits, according to a report for a Senate subcommittee.

Published Oct. 21, 2024
By
Susanna VogelStaff Reporter

Insurers used technology to increase denials services in skilled nursing homes between 2019 and 2022. *Adene Sanchez via Getty Images*

**Dive Brief:**

- A new Senate report sharply criticizes the country's three largest Medicare Advantage insurers — UnitedHealthcare, Humana and CVS — for allegedly limiting access to post-acute care to maximize profits.
- The insurers leveraged algorithmic tools to sharply increase claims denials for MA beneficiaries between 2019 and 2022, according to the report published Thursday by the Senate Permanent Subcommittee on Investigations. They most often denied coverage to patients in nursing homes, inpatient rehab hospitals and long-term hospitals, the report found.
- MA payers have previously come under fire from lawmakers for using algorithms to determine coverage. UnitedHealth and Humana have also been sued for denying MA beneficiaries care using the technology.

**Dive Insight:**

Prior authorization requires providers to submit paperwork to insurers certifying that treatments are medically necessary prior to performing them.

Insurers argue that prior authorization curbs unnecessary treatments, saving the healthcare system valuable dollars. Meanwhile, providers and other critics argue it's burdensome — and used by insurers to avoid paying for medical care.

In recent years, insurers have increased their denials of prior authorization requests, particularly for patients covered by Medicare Advantage.

The 54-page Senate report argues this uptick in denials is intentional.

“Medicare Advantage insurers are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities,” the report says.

Between 2019 and 2022, UnitedHealthcare, Humana and CVS each denied prior authorization requests for post-acute care “at far higher rates than they did for other types of care, resulting in diminished access to post-acute care for Medicare Advantage beneficiaries,” according to the report.

In those four years, UnitedHealth’s post-acute services denial rate increased from 8.7% to 22.7%, the report found. Meanwhile, UnitedHealth’s skilled nursing home denial rate increased ninefold. These increases coincide with UnitedHealth’s use of NaviHealth-backed nH Predict, an algorithmic tool used to manage claims denials, the Investigations subcommittee alleges.

The tool is at the center of a lawsuit filed in November 2023, which alleges UnitedHealth inappropriately relied on the algorithm to adjudicate MA claims despite knowing nH Predict was riddled with errors. UnitedHealth denies the lawsuit has merit.

CVS similarly rolled out a “Post-Acute Analytics” project in 2021, which harnessed AI to reduce money spent on skilled nursing facilities, according to the report.

In terms of savings, the initiative was a wild success. CVS initially expected the algorithm would save the company $10 million to $15 million in the first three years. However, several months later, CVS projected $77.3 million in savings during that same time period, the Investigations subcommittee found.

Similarly, Humana’s denial rate for long-term acute-care hospitals increased 54% between 2020 and 2022 following training sessions about evaluating prior authorization requests for post-acute services. The sessions allegedly included tips on how to justify denials when speaking to providers.

Research has shown patients who appeal preauthorization denials are likely to win. As of 2022, over 80% of appealed MA prior authorization denials were decided in patients’ favor. However, few beneficiaries actually appeal coverage denials, according to provider and patient advocacy groups.

In light of the findings, the Senate subcommittee recommended the CMS conduct targeted audits of insurers’ prior authorization data. It also asked regulators to consider expanding regulations governing the issue of predictive technologies to ensure workers aren’t bound by the tools’ recommendations when making final claims decisions.

Lawmakers have signaled interest in overseeing payers’ use of AI. Last spring, the Senate subcommittee held a hearing on AI’s role in increased denials.

“I want to put these companies on notice. If you deny lifesaving coverage to seniors, we’re watching, we will expose you, we will demand better, we will pass legislation if

necessary, but action will be forthcoming," Sen. Richard Blumenthal, D-Conn., chair of the Permanent Subcommittee on Investigations, said at the time.

# ‘Rationing by inconvenience’: Health insurers count on customers not appealing denials

## For many patients, the appeal process is just too much

*Adobe*

By Miranda Yaver

Jan. 23, 2025

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**RELATED STORY**

Unnecessary insurance claim denials compromise patient care and provider bottom lines

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Health Care

# How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them

**by Patrick Rucker, Maya Miller and David Armstrong**March 25, 5 a.m. EDT

## Internal documents and former company executives reveal how Cigna doctors reject patients' claims without opening their files. "We literally click and submit," one former company doctor said.

**REPUBLISH**
**Co-published with The Capitol Forum**

**Series:Uncovered**

How the Insurance Industry Denies Coverage to Patients

*ProPublica is a nonprofit newsroom that investigates abuses of power. Sign up to receive our biggest stories as soon as they're published.*

*Join the reporters Tuesday, March 28, for a virtual discussion with a former Cigna executive and other experts about America's broken health insurance system.*

When a stubborn pain in Nick van Terheyden's bones would not subside, his doctor had a hunch what was wrong.

Without enough vitamin D in the blood, the body will pull that vital nutrient from the bones. Left untreated, a vitamin D deficiency can lead to osteoporosis.

A blood test in the fall of 2021 confirmed the doctor's diagnosis, and van Terheyden expected his company's insurance plan, managed by Cigna, to cover the cost of the bloodwork. Instead, Cigna sent van Terheyden a letter explaining that it would not pay for the $350 test because it was not "medically necessary."

The letter was signed by one of Cigna's medical directors, a doctor employed by the company to review insurance claims.

Something about the denial letter did not sit well with van Terheyden, a 58-year-old Maryland resident. "This was a clinical decision being second-guessed by someone with no knowledge of me," said van Terheyden, a physician himself and a specialist who had worked in emergency care in the United Kingdom.

The vague wording made van Terheyden suspect that Dr. Cheryl Dopke, the medical director who signed it, had not taken much care with his case.

Van Terheyden was right to be suspicious. His claim was just one of roughly 60,000 that Dopke denied in a single month last year, according to internal Cigna records reviewed by ProPublica and The Capitol Forum.

The rejection of van Terheyden's claim was typical for Cigna, one of the country's largest insurers. The company has built a system that allows its doctors to instantly reject a claim on medical grounds without opening the patient file, leaving people with unexpected bills, according to corporate documents and interviews with former Cigna officials. Over a period of two months last year, Cigna doctors denied over 300,000 requests for payments using this method, spending an average of 1.2 seconds on each case, the documents show. The company has reported it covers or administers health care plans for 18 million people.

In the one hour and 31 minutes and 55 seconds you've been on this page, Cigna's doctors could have denied 6618 claims, according to company documents.

Before health insurers reject claims for medical reasons, company doctors must review them, according to insurance laws and regulations in many states. Medical directors are expected to examine patient records, review coverage policies and use their expertise to decide whether to approve or deny claims, regulators said. This process helps avoid unfair denials.

But the Cigna review system that blocked van Terheyden's claim bypasses those steps. Medical directors do not see any patient records or put their medical judgment to use, said former company employees familiar with the system. Instead, a computer does the work. A

Cigna algorithm flags mismatches between diagnoses and what the company considers acceptable tests and procedures for those ailments. Company doctors then sign off on the denials in batches, according to interviews with former employees who spoke on condition of anonymity.

“We literally click and submit,” one former Cigna doctor said. “It takes all of 10 seconds to do 50 at a time.”

Not all claims are processed through this review system. For those that are, it is unclear how many are approved and how many are funneled to doctors for automatic denial.

Insurance experts questioned Cigna’s review system.

Patients expect insurers to treat them fairly and meaningfully review each claim, said Dave Jones, California’s former insurance commissioner. Under California regulations, insurers must consider patient claims using a “thorough, fair and objective investigation.”

“It’s hard to imagine that spending only seconds to review medical records complies with the California law,” said Jones. “At a minimum, I believe it warrants an investigation.”

**Do You Have Insights Into Health Insurance Denials? Help Us Report on the System.**
Insurers deny tens of millions of claims every year. ProPublica is investigating why claims are denied, what the consequences are for patients and how the appeal process really works.

Name *

Email *

Phone

City of residence, State of residence

Which of the following applies to you? (Select all that apply)Which of the following applies to you? (Select all that apply)

I am a patient or family member of a patient. My insurer denied my claim or the claim of someone I know. I work for a health insurance plan and am familiar with the claims process. I work for an independent medical review company. I am a health care provider, doctor or clinician. I work for a public or regulatory agency that oversees health insurance.

Is there anything else you think we should know?

If you have any documents (e-mails, memos, photos, videos, etc.) you'd like to share, you can do so here. You can upload them here or use one of our more secure options.If you have any documents (e-mails, memos, photos, videos, etc.) you'd like to share, you can do so here. You can upload them here or use one of our more secure options.
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Within Cigna, some executives questioned whether rendering such speedy denials satisfied the law, according to one former executive who spoke on condition of anonymity because he still works with insurers.

“We thought it might fall into a legal gray zone,” said the former Cigna official, who helped conceive the program. “We sent the idea to legal, and they sent it back saying it was OK.”

Cigna adopted its review system more than a decade ago, but insurance executives say similar systems have existed in various forms throughout the industry.

In a written response, Cigna said the reporting by ProPublica and The Capitol Forum was “biased and incomplete.”

Cigna said its review system was created to “accelerate payment of claims for certain routine screenings,” Cigna wrote. “This allows us to automatically approve claims when they are submitted with correct diagnosis codes.”

When asked if its review process, known as PXDX, lets Cigna doctors reject claims without examining them, the company said that description was “incorrect.” It repeatedly declined to answer further questions or provide additional details. (ProPublica employees’ health insurance is provided by Cigna.)

Former Cigna doctors confirmed that the review system was used to quickly reject claims. An internal corporate spreadsheet, viewed by the news organizations, lists names of Cigna’s medical directors and the number of cases each handled in a column headlined “PxDx.” The former doctors said the figures represent total denials. Cigna did not respond to detailed questions about the numbers.

Cigna's explanation that its review system was designed to approve claims didn’t make sense to one former company executive. “They were paying all these claims before. Then they weren’t,” said Ron Howrigon, who now runs a company that helps private doctors in disputes with insurance companies. “You’re talking about a system built to deny claims.”

Cigna emphasized that its system does not prevent a patient from receiving care — it only decides when the insurer won’t pay. “Reviews occur after the service has been provided to the patient and does not result in any denials of care,” the statement said.

"Our company is committed to improving health outcomes, driving value for our clients and customers, and supporting our team of highly-skilled Medical Directors,” the company said.

## PXDX

Cigna’s review system was developed more than a decade ago by a former pediatrician.

After leaving his practice, Dr. Alan Muney spent the next several decades advising insurers and private equity firms on how to wring savings out of health plans.

In 2010, Muney was managing health insurance for companies owned by Blackstone, the private equity firm, when Cigna tapped him to help spot savings in its operation, he said.

Insurers have wide authority to reject claims for care, but processing those denials can cost a few hundred dollars each, former executives said. Typically, claims are entered into the insurance system, screened by a nurse and reviewed by a medical director.

For lower-dollar claims, it was cheaper for Cigna to simply pay the bill, Muney said.

“They don’t want to spend money to review a whole bunch of stuff that costs more to review than it does to just pay for it,” Muney said.

Muney and his team had solved the problem once before. At UnitedHealthcare, where Muney was an executive, he said his group built a similar system to let its doctors quickly deny claims in bulk.

In response to questions, UnitedHealthcare said it uses technology that allows it to make “fast, efficient and streamlined coverage decisions based on members benefit plans and clinical criteria in compliance with state and federal laws.” The company did not directly address whether it uses a system similar to Cigna.

At Cigna, Muney and his team created a list of tests and procedures approved for use with certain illnesses. The system would automatically turn down payment for a treatment that didn’t match one of the conditions on the list. Denials were then sent to medical directors, who would reject these claims with no review of the patient file.

Cigna eventually designated the list “PXDX” — corporate shorthand for procedure-to-diagnosis. The list saved money in two ways. It allowed Cigna to begin turning down claims that it had once paid. And it made it cheaper to turn down claims, because the company’s doctors never had to open a file or conduct any in-depth review. They simply denied the claims in bulk with an electronic signature.

“The PXDX stuff is not reviewed by a doc or nurse or anything like that,” Muney said.

The review system was designed to prevent claims for care that Cigna considered unneeded or even harmful to the patient, Muney said. The policy simply allowed Cigna to cheaply identify claims that it had a right to deny.

Muney said that it would be an “administrative hassle” to require company doctors to manually review each claim rejection. And it would mean hiring many more medical directors.

“That adds administrative expense to medicine,” he said. “It’s not efficient.”

But two former Cigna doctors, who did not want to be identified by name for fear of breaking confidentiality agreements with Cigna, said the system was unfair to patients. They said the claims automatically routed for denial lacked such basic information as race and gender.

“It was very frustrating,” one doctor said.

Some state regulators questioned Cigna’s PXDX system.

In Maryland, where van Terheyden lives, state insurance officials said the PXDX system as described by a reporter raises “some red flags.”

The state's law regulating group health plans purchased by employers requires that insurance company doctors be objective and flexible when they sit down to evaluate each case.

If Cigna medical directors are "truly rubber-stamping the output of the matching software without any additional review, it would be difficult for the medical director to comply with these requirements," the Maryland Insurance Administration wrote in response to questions.

Medicare and Medicaid have a system that automatically prevents improper payment of claims that are wrongly coded. It does not reject payment on medical grounds.

Within the world of private insurance, Muney is certain that the PXDX formula has boosted the corporate bottom line. "It has undoubtedly saved billions of dollars," he said.

Insurers benefit from the savings, but everyone stands to gain when health care costs are lowered and unneeded care is denied, he said.

## Speedy Reviews

Cigna carefully tracks how many patient claims its medical directors handle each month. Twelve times a year, medical directors receive a scorecard in the form of a spreadsheet that shows just how fast they have cleared PXDX cases.

Dopke, the doctor who turned down van Terheyden, rejected 121,000 claims in the first two months of 2022, according to the scorecard.

Category of Treatment: Outpatient

| Claim Reference | Date(s) of Service | Claim Total Charge | Charges Not Paid By Your Health Plan |
|---|---|---|---|
| [redacted] | 11/03/2021 – 11/03/2021 | $1,126.00 | $358.00 |

Cigna Health Management, Inc., on behalf of [redacted]

Dear Nicolas J Van Terheyden,

We received claim [redacted] for services received between 11/03/2021 – 11/03/2021 from Labcorp Holdings. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because the treatment is not medically necessary. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

**Note: We sent this letter to meet federal and state requirements.**

Van Terheyden's denial letter from Cigna Credit:highlights and redactions added by ProPublica

Dr. Richard Capek, another Cigna medical director, handled more than 80,000 instant denials in the same time span, the spreadsheet showed.

Dr. Paul Rossi has been a medical director at Cigna for over 30 years. Early last year, the physician denied more than 63,000 PXDX claims in two months.

Rossi, Dopke and Capek did not respond to attempts to contact them.

Howrigon, the former Cigna executive, said that although he was not involved in developing PXDX, he can understand the economics behind it.

"Put yourself in the shoes of the insurer," Howrigon said. "Why not just deny them all and see which ones come back on appeal? From a cost perspective, it makes sense."

Cigna knows that many patients will pay such bills rather than deal with the hassle of appealing a rejection, according to Howrigon and other former employees of the company. The PXDX list is focused on tests and treatments that typically cost a few hundred dollars each, said former Cigna employees.

"Insurers are very good at knowing when they can deny a claim and patients will grumble but still write a check," Howrigon said.

Muney and other former Cigna executives emphasized that the PXDX system does leave room for the patient and their doctor to appeal a medical director's decision to deny a claim.

But Cigna does not expect many appeals. In one corporate document, Cigna estimated that only 5% of people would appeal a denial resulting from a PXDX review.

## "A Negative Customer Experience"

In 2014, Cigna considered adding a new procedure to the PXDX list to be flagged for automatic denials.

Autonomic nervous system testing can help tell if an ailing patient is suffering from nerve damage caused by diabetes or a variety of autoimmune diseases. It's not a very involved procedure — taking about an hour — and it costs a few hundred dollars per test.

The test is versatile and noninvasive, requiring no needles. The patient goes through a handful of checks of heart rate, sweat response, equilibrium and other basic body functions.

At the time, Cigna was paying for every claim for the nerve test without bothering to look at the patient file, according to a corporate presentation. Cigna officials were weighing the

cost and benefits of adding the procedure to the list. “What is happening now?” the presentation asked. “Pay for all conditions without review.”

By adding the nerve test to the PXDX list, Cigna officials estimated, the insurer would turn down more than 17,800 claims a year that it had once covered. It would pay for the test for certain conditions, but deny payment for others.

These denials would “create a negative customer experience” and a “potential for increased out of pocket costs," the company presentation acknowledged.

But they would save roughly $2.4 million a year in medical costs, the presentation said.

Cigna added the test to the list.

## “It’s Not Good Medicine”

By the time van Terheyden received his first denial notice from Cigna early last year, he had some answers about his diagnosis. The blood test that Cigna had deemed “not medically necessary” had confirmed a vitamin D deficiency. His doctor had been right, and recommended supplements to boost van Terheyden’s vitamin level.

Van Terheyden Credit:Jared Soares for ProPublica

Still, van Terheyden kept pushing his appeal with Cigna in a process that grew more baffling. First, a different Cigna doctor reviewed the case and stood by the original denial. The blood test was unnecessary, Cigna insisted, because van Terheyden had never before been found to lack sufficient vitamin D.

“Records did not show you had a previously documented Vitamin D deficiency,” stated a denial letter issued by Cigna in April. How was van Terheyden supposed to document a vitamin D deficiency without a test? The letter was signed by a Cigna medical director named Barry Brenner.

Brenner did not respond to requests for comment.

Then, as allowed by his plan, van Terheyden took Cigna’s rejection to an external review by an independent reviewer.

In late June — seven months after the blood test — an outside doctor not working for Cigna reviewed van Terheyden’s medical record and determined the test was justified.

**UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings.**

The blood test in question "confirms the diagnosis of Vit-D deficiency," read the report from MCMC, a company that provides independent medical reviews. Cigna eventually paid van Terheyden's bill. "This patient is at risk of bone fracture without proper supplementations," MCMC's reviewer wrote. "Testing was medically necessary and appropriate."

Van Terheyden had known nothing about the vagaries of the PXDX denial system before he received the $350 bill. But he did sense that very few patients pushed as hard as he had done in his appeals.

As a physician, van Terheyden said, he's dumbfounded by the company's policies.

"It's not good medicine. It's not caring for patients. You end up asking yourself: Why would they do this if their ultimate goal is to care for the patient?" he said.

"Intellectually, I can understand it. As a physician, I can't. To me, it feels wrong."

In the one hour and 31 minutes and 55 seconds you've been on this page, Cigna's doctors could have denied 6618 claims, according to company documents.

Doris Burke contributed research.

**Filed under —**

- Health Care

March 10, 2025

**RE: House Bill 1481 – OPPOSE**

Dear Honorable Senator Lee and Members of the Committee,

On behalf of the National Association of Dental Plans (NADP), we appreciate the opportunity to provide comments in opposition to House Bill 1481. As introduced, this bill would create a minimum dental loss ratio (DLR) of 75 percent for dental benefit plans. HB 1481 would lead to increased premiums, reduced use and access to dental services, and a reduction in employer and consumer options for purchasing dental coverage.

Dental plans offer a wide variety of products and benefit designs compared with medical plans. Any measurement of a dental plan's value must reflect the fundamental differences between how medical and dental plans are structured, priced, offered, and purchased if it is to be accurate and meaningful to consumers. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5 percent.

In North Dakota, dental premiums are on average, about $33 per month[1] and medical premiums are, on average, about $708 per month.[2] At a 75 percent loss ratio, dental plans have just over $8 per member per month to cover administrative expenses. In contrast, medical plans have $177 to spend on similar administrative expenses per month. Dental and medical plan administrative requirements are similar and include fast and accurate claims payments, customer and dental provider services, network management, quality control, and consumer protections. The severe limitations placed on administrative resources imposed under the proposed loss ratio would leave consumers with plans that are administered less effectively. This small amount would not cover the cost of basic plan operations for even the most cost-efficient plans. If low-cost plans cannot cover their administrative expenses under the 75 percent loss ratio, those plans may be forced to no longer offer in North Dakota or to raise premiums to cover increased costs.

**Dental Plans and Oral Health**

House Bill 1481 has the potential to dramatically reduce the availability of dental coverage in North Dakota with negative effects on access to oral health care. According to a 2023 by the North Dakota Health & Human Services Oral Health Program, nearly one in three adults (31 percent) reported no dental visit in the past five years, with more than half of adults who are indigenous (51 percent) reporting the same.[3] Dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Consumers without dental coverage are far less likely to visit the dentist. Data shows that there is significant correlation between dental coverage

[1] NADP, 2024. Dental Benefits Report. (link)
[2] "Average Annual Singel Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation (2023). Employers typically contribute about $613 per month while employees typically contribute about $95 per month.
[3] North Dakota Health & Human Services Oral Health Program, 2023. Oral Health in North Dakota Opportunities and Need to Promote Oral Health Equity (link)

and visiting the dentist for regular, preventive exams, x-rays, and cleanings. Under a typical dental plan, preventive care is covered at 100 percent cost sharing to incentivize utilization and a regular relationship with a dentist. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

As a voluntary benefit most commonly offered as an employee benefit, dental insurance is highly price sensitive and an increase in premiums may lead to a reduction in dental coverage. Losing coverage often means patients must pay full list price for their dental care and a cleaning may cost hundreds of dollars out of pocket. As a result, many people without dental coverage skip regular preventive services to reduce costs and in the long term this increases their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions. For these reasons, we oppose House Bill 1481 and urge you not to advance the legislation.

We believe there are alternatives that would provide transparency for consumers and more appropriately evaluate the value of dental benefits. The NCOIL Dental Loss Ratio model[4] would allow the Department of Insurance to assess the appropriate loss ratios for plans while empowering the Department to take corrective action when a plan is inappropriately low. This model provides all the necessary data to ensure optimal transparency with the ability to remediate outlier plans.

Thank you for your consideration. We look forward to working with you to develop alternative avenues to meet the needs of North Dakotans.

Respectfully submitted,

Bianca Balale
Director of Government Relations
National Association of Dental Plans

*NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.*

[4] NCOIL Medical Loss Ratios for Dental (DLR) Health Care Services Plan Model Act

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine



**National Council of Insurance Legislators (NCOIL)**

# Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act

***Sponsored by Del. Steve Westfall (WV)**
***Co-sponsored by Rep. Rita Mayfield (IL)**

***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on January 26, 2024 and the NCOIL Executive Committee on April 14 2024.**

## Table of Contents



## Section 1. Title

This Act shall be known and cited as the "[State] Medical Loss Ratios for Dental (DLR) Health Care Services Plans Act."

## Section 2. Purpose

The purpose of this Act is to 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.

## Section 3. Definitions

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Dental carrier" or "carrier" means 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.

(c) "Dental health care service plan" or "plan" means any plan that provides coverage for dental health care services to enrollees in exchange for premiums, and does not include plans under Medicaid or CHIP.

(d) "Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated pursuant to subsection (i) in this section.

(i) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

(A) 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 at 45 CFR 158.140(a); and

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

(1)(a) The Commissioner shall define by rule:

(I) expenditures for clinical dental services;

(II) activities that improve dental care quality;

1. Activities conducted by an issuer intended to improve dental care quality shall not exceed five percent of net premium revenue

(III) overhead and administrative cost expenditures; and

(ii) 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 carriers offering health benefit plans in the state. Overhead and administrative costs must not be included in the numerator.

**Section 4. Transparency of Patient Premium Expenditures**

(a) A carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Dental Loss Ratio (DLR) 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). The filing must also report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

(b) The DLR reporting year shall be for the fiscal year during which dental coverage is provided by the plan. All terms used in the DLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If data verification of the carrier's representations in the DLR annual report is deemed necessary, the commissioner shall provide the carrier with a notification 30 days to submit any information required by the Commissioner.

(d) By January 1 of the year after the Commissioner receives the dental loss ratio information collected pursuant to subsection (a) of this Section, 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 carriers by plan type by:

(i) Posting the information on the division's website; or

(ii) Providing the information to the administrator of an all-payer health claims database. If the Commissioner provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the Commissioner.

(e) The Commissioner shall report the data in this Section to the Legislature.

**Section 5. Excess Revenue and Rebate**

(a) The Commissioner shall aggregate dental loss ratios for each carrier by year pursuant to Section 4 for each market segment in which the carrier 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.

(1) Newer experience shall be subject to reporting standards at 45 CFR 158.121

(b) The Commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection 5(a), identify as outliers dental plans that fall outside 1 standard deviations of the average dental loss ratio, and report those plans to the legislature consistent with the manner set forth in subsections 4(e) and 4(d) above.

(1) A carrier shall not be considered an outlier if its DLR 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.

(c) The Commissioner shall investigate those carriers that report a DLR lower than 1 standard deviations from the mathematical average, and may take remediation or enforcement actions against them, including ordering such carriers to rebate, in a manner consistent with 45 C.F.R. Part 158(B) of the ACA all premiums paid above such amounts that would have caused said carrier to have achieved the mathematical average of the data submitted in a given year for a given market segment.

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

(e) A carrier subject to remediation in subsections (c) and (d) shall provide any rebate owing to a policyholder no later than xxxxx of the fiscal year following the year for which the ratio described in subsection (a) of this section was calculated. The Commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

(f) The Commissioner may promulgate rules that create a process to identify carriers that increase rates in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.

**Section 6. Rules**

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act.

**Section 7. Effective Date**

This Act shall take effect xxxxxxx.

MetLife
200 Park Avenue
New York, NY 10166

**Kerri Cutry**
Assistant Vice President
State Advocacy & Supervision

March 10, 2025

**RE: House Bill 1481 – OPPOSE**

Dear Chairman Lee and Committee Members:

Metropolitan Life Insurance Company ("MetLife") is a leader in providing dental benefits nationwide and strives to provide superior dental benefits at affordable prices to its customers. House Bill 1481 would create a dental minimum loss ratio (DLR) of 75 percent for dental benefit plans in North Dakota, a concept we believe has been inappropriately borrowed from Obamacare's medical loss ratio requirement for health insurance.

MetLife respectfully opposes House Bill 1481 because it would cause the cost of dental insurance to rise significantly, result in less consumer choice and competition, fewer options for employers to provide critical employee benefits, and ultimately, less people being able to afford essential dental coverage.

**DLR would Increase Premiums for Consumers**

House Bill 1481 will not impose additional benefits or "greater value" in dental products but will result in increased premiums, and severely limit choice of dental plan options in North Dakota. A 75 percent DLR would negatively impact North Dakota dental consumers, especially those in small employer groups, as their premiums would increase to cover administrative costs and dental plans would, unfortunately, find it difficult to offer economically priced dental programs with a required DLR.

The impact of setting a DLR is to limit how much dental plans may spend on expenses necessary to administer their plans, as a percentage of premium. Dental plans must necessarily incur costs for administration, just like any other business and employer in North Dakota. These expenses include general administration, processing of claims, compliance with regulatory requirements, and state-mandated consumer protections and commissions. Considering the average dental premium for North Dakota is $33, that would leave less than $9 to cover all of those expenses.

A 2024 University of California report found that premiums in some dental products would have to increase up to 266 percent to comply with a designated DLR, even after reducing profits and improving administrative efficiency.

Some may argue that dental plans will just decrease their expenses if the DLR is enacted. However, profit margins for dental plans are currently low, and plans are already efficient. This

is driven by the current free market with competition among many dental plans to offer the best coverage at the most affordable premium rates possible. This has led to a dental market where premiums have been remarkably low and stable over time, especially as compared with the rise in premium for health insurance, which does have to comply with a required medical loss ratio. Requiring a DLR would result in premium increases and threaten the affordability of dental insurance for North Dakotans.

**Dental Insurance is Voluntary and Price Sensitive**

Unlike medical insurance, dental insurance is a voluntary product. Like other voluntary insurance products, it is highly price sensitive. Studies have shown that an increase in premiums may cause a reduction in coverage. Especially at a time when medical costs and medical debt are at an all-time high, even a small rise in premiums is likely to lead to dropped coverage for many North Dakotans.

A 2024 National Association of Dental Plans survey showed that about 80 percent of respondents are currently satisfied or very satisfied with their dental plans. Almost half of those surveyed without coverage explained that they chose not to purchase dental insurance because the premiums are too high.

Therefore, we believe that setting a DLR in statute would not create a better dental marketplace, but instead lead even more North Dakotans to go without coverage.

**Consumers with Dental Coverage are More Likely to Visit Dentist**

Losing coverage often means patients must pay full list price for their dental care and a cleaning may cost hundreds of dollars out of pocket. For this reason, it is not surprising to see that studies show that consumers with dental insurance are more likely to go to the dentist. In fact, dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Under a typical dental plan, preventive care is covered at 100% cost sharing to incentivize utilization and a regular relationship with a dentist.

**HB 1481 Could Negatively Impact North Dakotans Health**

We believe and studies show that oral health is very important for overall health. This is why we are concerned about the impacts of House Bill 1481. Requiring a 75 percent DLR has the potential to dramatically reduce the availability of dental coverage in North Dakota with negative effects on access to oral health care.

Studies show that consumers with dental insurance are more likely to go to the dentist. In fact, dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

However, many people without dental coverage skip regular preventive services to reduce costs and in the long term, this increases their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions, and other health conditions.

**MetLife Urges You to Oppose HB 1481 and Consider Alternatives**

For these reasons and the reasons outlined by others today in their opposition testimony, other legislatures around the country have considered these serious consequences and rejected similar proposals to set an enumerated DLR by statute, and instead have adopted DLR reporting mechanisms similar to the NCOIL Model for greater transparency while protecting the health of their residents.

Because losing coverage can lead to a concerning decline in health for some North Dakotans, we urge the Committee to consider these unintended negative consequences of House Bill 1481 and alternative approaches such as the NCOIL model. Thank you for your thoughtful consideration.

Sincerely,

Kerri Cutry
Assistant Vice President, State Advocacy & Supervision
MetLife
(646) 416-2158

Good morning, Chairwoman Lee and members of the Committee,

My name is Kate McCown, and I am the Vice President of Compliance at Ameritas Life Insurance Corp. for our supplemental insurance products, which include dental, vision, and hearing insurance. Today, we are testifying in opposition of HB 1481, which seeks to require dental plan carriers to meet a dental loss ratio of 75%.

In 2022, Massachusetts passed a ballot initiative applying an 83% loss ratio, however, residents of that state were not given the full detail of the potential ramifications of applying a loss ratio that is intended for medical plans. Seven dental carriers have stopped offering dental plans in the individual and/or small group markets, or have exited the state entirely, because they could not continue to provide affordable plans. Ameritas stop selling in the individual and smaller group markets in Massachusetts.

At an 83% dental loss ratio, Ameritas could not create affordable products for individuals or small groups that would provide meaningful benefits while still covering minimum expenses for fraud waste and abuse services, provider credentialling, services that reduce member out of pocket costs, external distribution costs, and internal operating expenses.

For larger groups we were able to remain in the market by limiting coverage options groups could purchase to more expensive plan designs. For larger groups, distribution costs tend to be lower as a percentage of premium and there is more premium per policy to spread fixed administrative costs.

Here is a sample breakdown of expenses on an individual dental policy in North Dakota with a monthly premium of $53.76:

- After claims were paid, Ameritas used 34%, or $18.49, to cover expenses,
- 9.68%, or $5.20 went to claims, administrative, charity, and overhead expenses,
- 16.7% or $8.98 went to external distribution expenses,
- 2.3% or $1.24 went to expenses that reduce member out of pocket costs,
- 2.6% or $1.41 went to state/federal taxes and regulatory fees,
- And only 3.1%, or $1.67 of a $53.76 monthly premium was profit.

Excluding taxes and regulatory fees, an increase in the loss ratio of this specific plan from 66% to 75% would result in an operating deficit of 9.0%.

The bottom line is that a loss ratio as required under this bill will raise dental premiums, which is counterproductive to increasing access to quality care and improving oral health for North Dakotans. A report by the impartial organization, the California Health Benefits Review Program (CHBRP) at the University of CA/Berkley, analyzed proposed dental loss ratio legislation in California last year.

They found that dental loss ratios would lead to premium increases, market withdrawals, reductions in producer compensation, dropped coverage, a move to ASO, and market consolidation.

For these reasons, we oppose HB 1481 and urge you not to move the bill forward in its current form. We would consider the NCOIL model, as it is a compromise between the dental industry and the American Dental Association and allows for market correction without unintended consequences to insureds in North Dakota. Thank you very much for your time and consideration.

DELTA DENTAL®

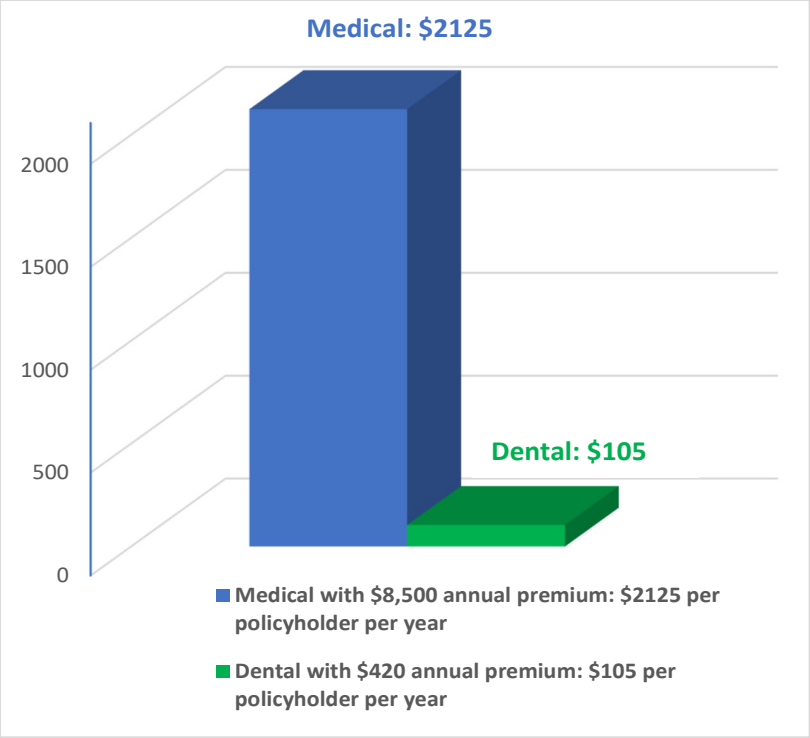
## HB1481 (THE 75% DENTAL LOSS RATIO BILL) IS WRONG FOR NORTH DAKOTA

**The Bill Is Unnecessary Because North Dakota Already Regulates Dental Premiums and Policies**. Dental carriers already must file their premium rates and policy forms with the North Dakota Insurance Department before use in North Dakota. The Insurance Department may disapprove rates or forms if the benefits provided are not reasonable in relation to the premiums charged, or are unfair or inequitable.[1] As a result, under existing law, the Insurance Department already determines that dental premiums are reasonable for the benefits provided and supported by sound actuarial data. HB1481 is unnecessary.

**The Bill Is Impractical Because Dental Coverage is Different Than Medical Coverage**. The dental loss ratio legislation in HB1481 is based on medical loss ratio provisions in the Affordable Care Act. As noted below, dental coverage is much different than medical coverage, resulting in far different loss ratio expectations. For this reason, Congress rejected mandating dental loss ratios in the ACA.

The fixed costs of administering dental plans require disproportionately larger portions of revenue than medical plans (i.e., a lower loss ratio). Dental premiums are often about 1/20th the cost of medical premiums, but dental carriers have many of the same fixed costs for operations.

### 75% Loss Ratio Medical v. Dental—Available Funds to Operate Insurer (Per Policyholder):




**Examples of Fixed Costs:**

- Claims processing
- Customer service
- IT and data security
- Actuarial, underwriting, finance, accounting
- Provider credentialing & enrollment
- Member enrollment & eligibility
- Policy issuance, member ID cards
- Broker commissions
- Insurance (cyber security, property, workers' comp, etc.)
- Government rate & policy filings & compliance
- Philanthropic & community spending
- Building and office space
- Personnel & administrative costs

[1] *See e.g* NDCC 1.26-30

As the above figure illustrates, a medical plan with a $708 monthly premium and 75% loss ratio has $2,125 per year ($177.08 per month) for benefit administration and operations, but a dental plan with a $35 monthly premium and 75% loss ratio only has $105 per year ($8.75 per month) for benefit administration and operations—even though medical and dental plans have similar types of fixed operational costs.

**The Bill's Unintended Consequences Are Bad for Patients.** Massachusetts recently adopted a ballot initiative requiring an 83% dental loss ratio. The standard went into effect in 2024. **No state has adopted the Massachusetts dental loss ratio standard**—but at least 20 states have rejected it. Unintended consequences from HB1481 include:

- **Premiums increases.** Insurance experts predict that dental carriers will have to raise premiums to meet a loss ratio mandate. In 2024, the State of California studied *proposed* legislation similar to HB1481 and found that an 85% dental loss ratio would increase individual and small group premiums by 78-266%. The California Legislature rejected the dental loss ratio proposal. If dental premiums increase beyond purchasers' budgets, people and employers will stop buying dental coverage and employers will shift more costs to employees.
- **Fewer people receiving treatment**. According to one study, individuals with dental insurance were 49% more likely to have visited the dentist for check-ups or cleanings in the last 6-months.[2] If purchasers are forced to drop dental coverage due to increased premiums caused by this legislation, fewer people will receive oral health care—and their oral health will suffer.
- **Dental plan participation**. While it is still too early for the impacts of the Massachusetts dental loss ratio law on dental markets to be fully realized, **at least seven (7) insurance companies have already exited at least one market in Massachusetts** since the dental loss ratio standard took effect. More may follow suit. No carriers have entered the market to fill this vacuum.

**A 75% Threshold Would Eliminate Most Individual and Small Group Plans from the Market.** Based on the publicly available data on the Systems for Electronic Rates and Forms Filing (SERFF) over the last 5 years in North Dakota, 63 out of 67, or 94% of the plans filed in the individual market (off-exchange) would have been *rejected* at a 75% mandate. Similarly, 27 out of 33, or 82% of the plans filed in the small group market would have been *rejected* at 75% mandate. As currently drafted, the bill requires the Insurance Department to separately review the loss ratios of each separate *product* offered by a dental insurance company and reject products of insurers subject to the mandate that do not meet a 75% loss ratio. In other words, as currently drafted, the bill does not permit the Insurance Department to approve a product of an insurer subject to the law with a loss ratio of less than 75% even if the aggregate combined loss ratio of all products offered by the insurer are greater than 75%. As a result, if a dental insurer subject to the law has an aggregate loss ratio of 80% achieved through its higher loss ratio for its large group plans, but all of its individual and small employer group products have loss ratios under 75%, the individual and small employer group products would be rejected and not permitted to be sold in North Dakota.

[2] National Association of Dental Plans Consumer Survey

# HB 1481

## Testimony in Opposition

Al Berg

Employee Benefit Risk Advisor

Servicing Employers throughout North Dakota

# 30+ Years Experience with Dental Insurance

Design, Bid, and Enroll dental plans covering several thousand employees.

Discuss “Pain Points” dentists have with dental insurance.

# Concerns of Dentists

- Reduced Fees if joining network — Will they gain or lose patients?
- Coverage denied or delayed
- Administrative time and expense
- Insurers gain further control over reimbursements and covered services

# State of the “Union”

Relationship between Dentists and Insurers is “challenging.”

Hasn’t always been that way.

# Dental Service Corporation

Developed between Dentists and BCBSND.

Virtually all dentists in ND participated.

Reimbursements were close to Retail.

# Back in the Day

Chairs were filled with new and used mouths.

BCBSND was good administrator.

Win/Win/Win for Employers, Patients, and Dentists.

# Plan Design

## Diagnostic & Preventive **100%**

- Exams, Cleanings, X-Rays, Fluoride

## Basic **80%**

- Fillings, Endodontics, Periodontics

## Major **50%**

- Crowns, Bridges, Dentures, Oral Surgery

Pays up to $1,000 - $1,500 per person.
Orthodontics can be added.

# What Dental Insurance is Designed To Do

## Get people in for preventive oral care

- No cost to patient

## **Assist** with Major Services

- Make cost more manageable for costly procedures
- Plan pays half; Patient pays half

# Half Full or Half Empty?

*Testimony from Dentist for HB 1481*

"I have this discussion far too often with many of my patients. Once treatment options have been viewed and determined for the patient's best interest, they bring up the same question, 'How much does my insurance cover?' It is a very difficult discussion to have. It often is the determining factor for their dental care, not what the best clinical choice for their body is. All this money spent for dental coverage, yet very little is paid by the insurance company toward treatment. This situation, unfortunately, leads to delayed treatment, or sometimes, no treatment at all."

# What Dental Insurance Does . . . and Doesn’t Do

Pays for Preventive Care

**Assists** with Major Services

# Proposed Legislation Will Not – *Cannot* – Change Payment

Insurance pays according to **terms of contract.**

100/80/50 is the “sustainable balance” learned from experience.

Dental Insurance is very price sensitive.

# What Happened with Dental Insurance in North Dakota?

The World came to North Dakota.

New employers came to the state . . . along with their benefit plans.

Plan designs were/are the same: 100/80/50

Reimbursements were at Wholesale for those on an *Out-of-State* dental plan.

# In State vs. Out-of-State Plans

Most dental plans with ND employers pay out-of-network claims based on what majority of dentists charge for services.

Over many years, complaints are minimal for in-state plans.

Some plans in a few other states have punitive reimbursements for non-participating dentists.

NDDA is right in uniting against the overreach of some out of state dental plans.

# Results of Proposed Legislation

**Large employer plans will be unaffected.**

- Enough “Economies of Scale” to meet 75% loss ratio requirement.

**Insurance companies will withdraw from small group dental market.**

- Won’t meet loss ratio rules.
- Comparison of Medical and Dental loss ratios is a false equivalency.
- Groups of 100 or less will not have option for dental insurance.

# Results of Proposed Legislation

"Excess Profits" will not go toward cost of care.

- Plan pays according to terms of Contract.

Will not affect plans with out-of-state insurers.

- NDID does not have jurisdiction over plans maintained by employer based in another state.

# Solution in Seach of a Problem

## ND Dental Insurance market is very competitive.

- Insurers make a reasonable profit for administering the dental plan, and brokers are paid for marketing and servicing it.
- No margin to fund “high executive salaries and shareholder dividends.”

## Dental market is self-correcting.

- Charge too much and the group can move to another company.

# Solution in Seach of a Problem

## Commissioner Godfread:

“Dental plans function differently than medical plans. They are designed to emphasize preventive care, with higher cost-sharing on major procedures to keep premiums low and maintain affordability. A rigid MLR requirement could disrupt this balance, leading to higher premiums and reduced plan choices.”

“Based on the data that (our department) has shared with the committee, most of North Dakota’s dental insurers—including the two largest in the state—are already operating at or near an 82% loss ratio. Given this data, we are struggling to identify the specific consumer harm that this bill aims to address. What tangible problem is being solved? Without a clear justification, this legislation seems to add administrative burden without clear consumer benefit.”

# Vote NO on HB 1481

## Don't be misled into reducing affordable preventative dental care options.

### 1. Medical Loss Ratios Are Not Appropriate for the Dental Industry

- Dental insurance operates in a much different way than medical insurance. Dental plans emphasize ***preventive care***, while medical insurance covers catastrophic events as they happen. Imposing medical loss ratios (MLRs) on dental plans ignores these fundamental differences.
- Dental premiums are significantly lower than medical premiums. While an 75% MLR leaves medical insurers with over **$175** per member per month for administrative costs, dental insurers would have *less than **$9***—jeopardizing their ability to function.
- A 75% MLR would likely eviscerate the small group market: an initial review shows that ***over 90% of the products filed over the last 5 years would have been rejected under this standard.***

### 2. A Solution in Search of a Problem

- North Dakota *already* regulates dental insurance rates through the Insurance Department, which ensures that premiums are fair and reasonable.
- Dental insurance costs have remained stable, with several plans even experiencing negative price growth over the last five years.
- No widespread consumer complaints or evidence of excessive profits justify this intervention.

### 3. The Need for Data Before Policy Change

- Other states that have implemented similar policies have seen unintended consequences, including *decreased competition* and **increased costs**.
- Instead of hastily imposing premature regulations, North Dakota should collect sufficient data on the dental insurance market to assess whether changes are necessary.

### 4. Massachusetts' Experience Shows the Dangers

- Massachusetts enacted a dental MLR requirement in 2022, leading to several insurers opting to exit small group and individual markets, resulting in sizable market shrinkage.
- In California, a study found that a similar 85% dental MLR would increase small-group premiums by **78% to 114%.**
- *Higher premiums will result in employers dropping dental coverage, **reducing access to dental care.***

### 5. Government Should Not Intervene in a Healthy Market

- HB 1481 would disproportionately affect small insurers and small businesses, forcing them to raise costs, exit the market, or reduce staffing ***(costing North Dakotans jobs)***.
- Large employers and self-insured plans, which cover nearly half of all commercial dental plan enrollees, are exempt from the bill; leaving smaller businesses and individuals to bear the burden.
- Government overreach in a functioning market *discourages investment, decreases healthy competition, and stifles innovation in dental care.*

NATIONAL ASSOCIATION OF DENTAL PLANS

ACLI

AHIP

# Vote NO on HB 1481

| CLAIM | REALITY |
| --- | --- |
| MLRs ensure patient premiums are spent on care instead of overhead. | Administrative costs are essential for processing claims, customer service, fraud prevention, and network management. If insurers cannot cover these costs, *they will raise premiums or exit the market*. |
| MLRs will lead to lower out-of-pocket costs for patients. | In Massachusetts, the **opposite** occurred—fewer insurance choices, higher premiums, and decreased access to care. |
| This bill follows the Affordable Care Act model for medical insurance. | Congress explicitly excluded dental insurance from the ACA's MLR requirements *because dental plans function differently*. |
| **Premium increases are a scare tactic: HB 1481 prevents unjustified increases.** | Studies from California and Massachusetts show that mandated MLRs *do* increase premiums, **significantly.** |
| Rebates will return excess premiums to patients. | The goal should be sustainable insurance pricing, rather than creating a *new* administrative burden of refunding small-dollar rebates, likely **increasing** costs. |
| **This policy has bipartisan support, as seen in Massachusetts.** | Many states have recently rejected similar measures, recognizing the potentially ***drastic negative impact*** on the market, consumers, and citizens. |

The proponents of HB 1481 would like to see more transparency, accountability, and an assurance that a reasonable amount of premiums is spent on care; the **NCOIL Model**, a compromise between the dental industry and the American Dental Association, would achieve these goals *without* disrupting the market (like is now being seen in Massachusetts).

- Authorizes the trained and knowledgeable experts at the **Department of Insurance** to assess appropriate loss ratios for the market;
- Empowers the Department of Insurance to take remedial action when a plan's loss ratio is inappropriately low;
- Allows for flexibility to determine whether a plan's loss ratio may be appropriately low – for example, when a plan is in its first year and must build up reserves;
- Requires insurers to report MLRs providing all the necessary data to ensure optimal transparency ;
- Protects North Dakotans from rising costs and reduced access to affordable plans.

**House Bill 1481**
**North Dakota Senate Health and Human Services Committee**
**AHIP Testimony**

Thank you for the opportunity to speak before you today. My name is Alex Kelsch, and I am testifying today on behalf of America's Health Insurance Plans (AHIP). [1]

AHIP respectfully opposes HB 1481 because this bill would create unintended consequences that severely impact access to dental care and benefits for North Dakotans. As amended, this bill would create a dental minimum loss ratio (DLR) of 75% for dental benefit plans. This has the potential to lead to increased premiums, reduced use and access to dental services, and a reduction in employer and consumer options for purchasing dental coverage.

**Dental Plans Differ from Medical Plans.** Dental plans offer a wide variety of products and benefit designs compared with medical plans. Any measurement of a dental plan's value must reflect the fundamental differences between how medical and dental plans are structured, priced, offered, and purchased if it is to be accurate and meaningful to consumers.

Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventive services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Consumers share a higher percentage of the cost for restorative procedures such as crowns, periodontal surgery, and dentures. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5%.

In North Dakota, dental premiums are on average, about $33 per month[2] and medical premiums are, on average, about $708 per month.[3]. Under HB 1481, the 75% loss ratio requirement would leave only a small amount which would not cover the cost of basic plan operations for even the most cost-efficient plans: administration; claims systems; compliance; and state-mandated consumer protections and commissions. If low-cost plans cannot cover their administrative expenses under the 75% loss ratio, those plans may be forced to no longer offer in North Dakota or to raise premiums to cover increased costs.

Furthermore, while HB 1481 attempts to reduce the impact of the loss ratio requirement by exempting plans with less than 1,000 covered lives in the state, this language does not address AHIP's concerns. While the threshold would enable plans that have very small levels of coverage to avoid the harmful effects of the DLR, it in essence caps growth for dental plans that do not have an existing presence in the North Dakota dental benefits market. Under this proposal, new dental plans are disincentivized from growing their business in the state and would be significantly hindered from investing in acquiring new groups or participating in the individual marketplace.

In Massachusetts, the only state to adopt a mandatory dental loss ratio, the market for dental insurance has contracted significantly, with at least 8 fewer carriers in the small group and individual markets – a 25% decline – since the imposition of the DLR in 2022. An independent analysis of similar bills indicates that a mandated dental loss ratio of 85% could raise premiums for dental coverage by 114% for small groups, and 78% for the individual market.[4] The analysis highlighted the risk that such a sudden and rapid increase in the cost of coverage will lead many small businesses to forgo dental plans for their employees and reduce access to oral health care.

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[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.
[2] NADP, 2024. Dental Benefits Report. (link)
[3] "Average Annual Singel Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation (2023). Employers typically contribute about $613 per month while employees typically contribute about $95 per month
[4] *AB 2028 Medical Loss Ratios (Dental)*. California Health Benefits Review Program. April 12, 2024.

**Dental Plans and Oral Health.** HB 1481 has the potential to reduce the availability of coverage through dental insurance coverage, options, and affordability in North Dakota would have negative effects on oral health care. Dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Under a typical dental plan, preventive care is covered at 100% cost sharing to incentivize utilization and a regular relationship with a dentist. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

The purchase of dental insurance has been shown to be highly price sensitive and therefore an increase in premiums may lead to a reduction in the purchase of dental coverage. Losing coverage often means patients must pay full list price for their dental care, which has a significant impact on consumers as just a cleaning may cost hundreds of dollars out of pocket. As a result, many people without dental coverage skip regular preventive services to reduce costs, in the long-term increasing their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions.

**AHIP Recommendation.** For these reasons, AHIP opposes HB 1481 and we urge you not to advance the legislation. Thank you for your consideration. We look forward to working with you to develop effective avenues to evaluate the value of dental benefits in North Dakota.

**Michael B. Hickey**
Director
State Government Relations

March 10, 2025

Chairwoman Judy Lee, Chair and Senate Human Services Committee members
North Dakota Senate Human Services Committee
North Dakota State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Dear Chairwoman Lee and Senate Human Services Committee:

We appreciate the opportunity to provide comments regarding HB 1481. Aflac is a leading provider of supplemental health insurance in the United States. When a policyholder or insured gets sick or hurt, Aflac pays cash benefits directly to the insured. For more than six decades, Aflac voluntary insurance policies have given policyholders the opportunity to focus on recovery, not financial stress. Aflac also offers dental insurance, and approximately 2,900 North Dakotans have our dental coverage.

Our dental plans provide coverage for preventive care and procedures from fillings to oral surgery. Benefits include reimbursement for covered dental services provided by either contracted or non-contracted providers. Deductibles, coinsurance (i.e. insurance percentages), and annual maximums apply, as elected by the covered employee's group sponsor.

HB 1481 mandates that dental insurance plans meet a 75% loss ratio and requires carriers to submit a report annually to the North Dakota Insurance Department. If a carrier does not meet the 75% loss ratio the carrier would be required to return excess premiums to insureds.

In 2010, President Obama signed the Patient Protection and Affordable Care Act into law which requires major medical health insurance plans in the individual and small group markets to meet an 80% loss ratio and plans in the large group market to meet an 85% loss ratio. At the time, the law also included an individual mandate, requiring people have major medical health insurance or face a tax penalty.

There are significant differences in applying a high loss ratio requirement to major medical products and dental products. Where an average monthly premium for major medical is $500 - $700, premiums for dental products are $30 - $50, leaving significantly less premium to pay for administrative costs, including network credentialing and recruiting; claims systems; compliance; and state-mandated consumer protections and commissions.

Massachusetts is the only state that has adopted a dental loss ratio mandate. Their 83% loss ratio requirement went into effect on January 1st of this year and has resulted in a chilling of the market. Fewer carriers are selling dental insurance in the Massachusetts market and Aflac is no longer selling or renewing dental policies in Massachusetts.

The proponents of HB 1481 would like to see more transparency, accountability, and an assurance that a reasonable amount of premiums is spent on care. The NCOIL Model, a compromise reached by the dental insurers and the American Dental Association, achieves these goals without disrupting the market like we are beginning to see in Massachusetts.

The NCOIL Model:

- Authorizes the experts at the North Dakota Insurance Department to assess appropriate loss ratios for the market.
- Empowers the North Dakota Insurance Department to take remedial action when a plan's loss ratio is inappropriately low.
- Allows for flexibility to determine whether a plan's loss ratio may be appropriately low – for example, when a plan is in its first year and must build up reserves.
- Requires insurers to report MLRs providing all the necessary data to ensure optimal transparency.
- Protects North Dakotans from rising costs and less access to affordable plans.

We suggest the mandate of HB 1481 would not be in the best interests of North Dakotans and their dental health needs. Thank you for considering these comments.

Sincerely,

Michael B. Hickey

# STATEMENT ON NCOIL MODEL LEGISLATION

January 23, 2024 – At the prompting of the National Conference of Insurance Legislators (NCOIL), the American Dental Association (ADA) and the National Association of Plans (NADP) entered into discussions to determine if both organizations could support model legislation with respect to the application of loss ratios to dental insurance. The model law to be adopted by NCOIL in January 2024 represents the patient work of NCOIL legislators and staff, and a compromise on specific terms that is agreed to by both ADA and NADP.

Both organizations view the model as offering guidance and clarity on dental loss ratio issues for state policymakers seeking to pass legislation on the issue.

Link to model law: https://ncoil.org/wp-content/uploads/2024/01/NCOIL-DLR-Model-Draft-1-23-24.pdf

American Dental Association

National Association of Dental Plans

About NADP:
NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

About the American Dental Association:
The not-for-profit ADA is the nation's largest dental association, representing 159,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859. The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance long has been a valuable and respected guide to consumer dental care products. The Journal of the American Dental Association (JADA), published monthly, is the ADA's flagship publication and the best-read scientific journal in dentistry. For more information about the ADA, visit ADA.org. For

more information on oral health, including prevention, care and treatment of dental disease, visit the ADA's consumer website MouthHealthy.org.

Testimony for HB 1481

Madam Chair Lee and Members Senate Human Services Committee,

I am Representative Jim Kasper and I represent District 46 in Fargo.

Thank you for having me this morning and I am happy to introduce HB 1481 which deals with dental loss ratios for dental plans from insurance carriers. This language and policy has been worked on for over four years going back to 2021(Representatives George Keiser and Mike Lefor on HB 1154) under the collaborative work between the North Dakota Dental Association and the North Dakota Insurance Department.

This bill, HB 1481, is about protecting and ensuring value for our constituents, the consumers in North Dakota, when purchasing and using dental insurance in our state. As an insurance broker, I am well aware of and have dealt with the issues in dental insurance for decades. One of my biggest problems is showing and guaranteeing the value of dental insurance plans to my clients. HB 1481 will solve this problem for not only us as brokers, but more importantly for the consumers and employers of our state.

**HB 1481 is a great protection for North Dakota Consumers.**

For the amendments on the bill, I would like to thank Chrystal Bartuska in the Insurance Department and Beth Dittus in Legislative Council. Through their help, we were able to get the perfect bill language that is satisfactory and proper for the Insurance Department before your committee for your deliberation. All of the changes/amendments to the bill were drafted at the end of January by legislative council under the direction of Ms. Bartuska to ensure this bill was:

1. placed in the proper area of code,
2. removed language that was redundant/duplicative and wasn't necessary, and
3. included a definition of "loss ratio" as requested by the ND Insurance Department

Our Industry Business and Labor Committee was overwhelmingly in support of the bill, but our discussion surrounded a few areas of deliberation. Our main areas discussed in the committee included:

1. What is the appropriate level for the "loss ratio" to be set at?(75%, 80% or 83%)
2. Making sure we give the Insurance Department and Dental Carriers time to adapt and implement these changes in North Dakota.
3. How do we protect small carriers in North Dakota?

Through the hard work of the ND Insurance Department, Legislative Council and the North Dakota Dental Association, I am very confident we have the bill in the appropriate/proper language and form to accomplish our legislative intent while ensuring the correct and consistent language in ND Insurance Code. In our committee, there was no appetite to change this language or work on other models or off of other state laws. We felt and voted that this language, HB 1481, before you is the right language for North Dakota. While we got the North Dakota data on "loss ratios" in our state too late for us to have meaningful deliberations as to what level(75%, 80%, or 83%) the bill should be set at; we are thankful that you have that data before you now to help you in your discussions and decision as to where you would like the threshold to be in our state to protect North Dakota consumers.

Thank you for your time today and I hope you would give HB 1481 a Do Pass Recommendation and support the actions by us, your colleagues in the House Chamber that voted overwhelmingly in support of this legislation. There has been a lot of hard work put in by the ND Insurance Department North Dakota Dental Association and Legislative Council on this bill.

# 2025 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Lincoln Room, State Capitol

HB 1481
3/19/2025

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.

11:12 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

**Discussion Topics:**

- Insurers Leaving the Market
- Aggregate Level and Plan Level Comparisons
- Defining Data Requirements
- Setting Standards
- Effective Date
- Dental Reporting Regulations

11:14 a.m. Senator Roers testified as neutral and submitted testimony #43021.

11:20 a.m. Chrystal Bartuska, ND Insurance Dept. Director, testified as neutral and submitted testimony #43031 and #43058.

11:52 a.m. Rebecca Fricke, PERS Executive Director, testified as neutral.

11:58 a.m. William Sherwin, ND Dental Association Executive Director, testified in favor.

12:10 p.m. Dennis Pathroth, American Council of Life Insurance, testified in favor and submitted testimony #43057.

12:13 p.m. Chairman Lee closed the hearing.

*Elizabeth Reiten for Andrew Ficek, Committee Clerk*

25.1250.03003
Title.

Prepared by the Legislative Council staff for Senator Roers
March 17, 2025

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.

25.1250.03000

Sixty-ninth
Legislative Assembly
of North Dakota

# ENGROSSED HOUSE BILL NO. 1481

## FIRST ENGROSSMENT

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 reporting requirements; ~~and to provide an effective date.~~

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA**

~~**Dental insurer rates - Approval.**~~

~~1. 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 is less than seventy-five percent.~~

~~2. a. If the annual dental loss ratio for a dental benefit plan is less than 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 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. 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.~~

**SECTION 1. AMENDMENT** A new section to chapter 26.1-36.9-01 of the North Dakota Century Code is created and enacted as follows:

Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated by dividing the numerator by the denominator as determined by subsection ___.

SECTION 2. AMENDMENT A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Calculation of Dental Loss Ratio (DLR).**

1. The dental loss ratio is calculated by dividing the numerator by the denominator, where:

a. 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 at 45 CFR 158.140(a); and

b. The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community

expenditures as defined at 45 CFR 158.162(c), and any other payments required by federal law.

**SECTION 3. AMENDMENT** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Transparency Reporting to Commissioner.**

1. A dental insurer that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Dental Loss Ratio (DLR) annual report with the Commissioner that is organized by market and product type and is filed in a manner prescribed by the commissioner.

2. The DLR reporting year shall be for the last calendar year for the dental benefit plans provided by the dental insurer and submitted to the Commissioner by April 30.

3. If data verification of the dental insurer representations in the DLR annual report is deemed necessary, the commissioner shall provide the dental insurer with a notification 30 days to submit any information required by the Commissioner.

4. After the Commissioner receives the dental loss ratio information collected pursuant to subsection 1 of this Section, the Commissioner shall make the information, including the aggregate dental loss ratio and other data reported, available to the public the departments website that allows members of the public to compare dental loss ratios among dental insurers by market type.

**SECTION 4. AMENDMENT** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Rule Making Authority.**

The Commissioner may adopt rules as necessary to effectuate the provisions of this section.

**Analysis: Department of Insurance Data Merged**
**Dental Insurer (Health and Life) Premiums, Losses and Market Share**

| Company Name | Domicile | Direct Premiums Written | Market Share | Cumulative Market Share | Direct Premiums Earned | Direct Losses |
|---|---|---|---|---|---|---|
| Delta Dental of MN | MN | 26,487 | 30.51% | 30.51% | 26,473 | 21,717 |
| BCBS of ND | ND | 19,784 | 22.79% | 53.30% | 19,784 | 16,161 |
| Metropolitan Life Ins Co | NY | 8,765 | 10.10% | 63.40% | 8,765 | 7,609 |
| Standard Ins Co | OR | 4,947 | 5.70% | 69.10% | 4,947 | 3,661 |
| Companion Life Ins Company | SC | 3,963 | 4.57% | 73.67% | 3,963 | 3,201 |
| Ameritas Life Ins Corp | NE | 3,370 | 3.88% | 77.55% | 3,370 | 2,285 |
| American Family Life Assur Co of Col | NE | 2,872 | 3.31% | 80.86% | 2,872 | 1,499 |
| Principal Life Ins Co | IA | 2,541 | 2.93% | 83.79% | 2,541 | 2,169 |
| Starmount Life Ins Co | ME | 2,073 | 2.39% | 86.18% | 2,073 | 1,394 |
| UnitedHealthcare Ins Co | CT | 1,984 | 2.29% | 88.47% | 1,984 | 1,523 |
| United Of Omaha Life Ins Co | NE | 1,215 | 1.40% | 89.87% | 1,215 | 919 |
| US Br Sun Life Assur Co of Canada | MI | 1,069 | 1.23% | 91.10% | 1,069 | 1,168 |
| Guardian Life Ins Co Of Amer | NY | 840 | 0.97% | 92.07% | 840 | 652 |
| Cigna Hlth & Life Ins Co | CT | 747 | 0.86% | 92.93% | 747 | 608 |
| Best Life & Hlth Ins Co | TX | 658 | 0.76% | 93.69% | 658 | 389 |
| ManhattanLife Ins & Ann Co | TX | 599 | 0.69% | 94.38% | 599 | 422 |
| Equitable Financial Life Ins Co of A | AZ | 541 | 0.62% | 95.00% | 541 | 539 |
| Reliance Standard Life Ins Co | IL | 534 | 0.62% | 95.62% | 534 | 283 |
| Humana Ins Co | WI | 502 | 0.58% | 96.20% | 504 | 277 |
| Colonial Life & Accident Ins Co | SC | 473 | 0.54% | 96.74% | 473 | 338 |
| Aetna Life Ins Co | CT | 459 | 0.53% | 97.27% | 459 | 299 |
| Physicians Mut Ins Co | NE | 434 | 0.50% | 97.77% | 434 | 262 |
| National Guardian Life Ins Co | WI | 419 | 0.48% | 98.25% | 419 | 346 |
| Dentegra Ins Co | DE | 386 | 0.44% | 98.69% | 385 | 255 |
| Lincoln Natl Life Ins Co | IN | 336 | 0.39% | 99.08% | 336 | 355 |
| United Concordia Ins Co | AZ | 134 | 0.15% | 99.23% | 134 | 121 |
| Nationwide Life Ins Co | OH | 117 | 0.13% | 99.36% | 117 | 104 |
| Mutual Of Omaha Ins Co | NE | 103 | 0.12% | 99.48% | 103 | 62 |
| Golden Rule Ins Co | IN | 95 | 0.11% | 99.59% | 95 | 69 |
| National Hlth Ins Co | TX | 94 | 0.11% | 99.70% | 94 | 40 |
| Healthpartners Ins Co | MN | 87 | 0.10% | 99.80% | 87 | 80 |

Market Share by Line of Business - Health

Selected Criteria - Year: 2023 State: ND Codelist Basis: Business Written Round by Thousands: Yes Include Zero Companies: Yes Business Type: Health

| Group Code | Company Name | Domicile | Premiums Written | Market Share | Premiums Earned | Losses Incurred | Pure Direct Loss Ratio |
|---|---|---|---|---|---|---|---|
| 4959 | Delta Dental of MN | MN | 26,487 | 55.79% | 26,473 | 21,717 | 82.03% |
| | BCBS of ND | ND | 19,784 | 41.67% | 19,784 | 16,161 | 81.69% |
| 119 | Humana Ins Co | WI | 502 | 1.06% | 504 | 277 | 54.96% |
| 2479 | Dentegra Ins Co | DE | 386 | 0.81% | 385 | 255 | 66.23% |
| 812 | United Concordia Ins C | AZ | 134 | 0.28% | 134 | 121 | 90.30% |
| 707 | Golden Rule Ins Co | IN | 95 | 0.20% | 95 | 69 | 72.63% |
| 1258 | Healthpartners Ins Co | MN | 87 | 0.18% | 87 | 80 | 91.95% |
| 707 | UnitedHealthcare Ins C | IL | 0 | 0% | 0 | 0 | 0% |
| 119 | Compbenefits Ins Co | TX | 0 | 0% | 0 | 0 | 0% |
| | Granular Ins Co | SC | 0 | 0% | 0 | 0 | 0% |
| 1552 | Medica Hlth Plans | MN | 0 | 0% | 0 | 0 | 0% |
| 707 | All Savers Ins Co | IN | 0 | 0% | 0 | 0 | 0% |
| 4979 | Lasso Hlthcare Ins Co | TX | 0 | 0% | 0 | 0 | 0% |
| 1 | SilverScript Ins Co | TN | 0 | 0% | 0 | 0 | 0% |
| 1 | Accendo Ins Co | UT | 0 | 0% | 0 | 0 | 0% |
| 1258 | Group Hlth Plan Inc | MN | 0 | 0% | 0 | 0 | 0% |
| 261 | Omaha Hlth Ins Co | NE | 0 | 0% | 0 | 0 | 0% |
| 707 | Care Improvement Plu | NE | 0 | 0% | 0 | 0 | 0% |
| 1 | Aetna Hlth Ins Co | PA | 0 | 0% | 0 | 0 | 0% |
| 1246 | Sanford Hlth Plan | SD | 0 | 0% | 0 | 0 | 0% |
| 901 | Medco Containment Li | PA | 0 | 0% | 0 | 0 | 0% |
| 1 | First Hlth Life & Hlth In | TX | 0 | 0% | 0 | 0 | 0% |
| 119 | Humanadental Ins Co | WI | 0 | 0% | 0 | 0 | 0% |
| 367 | Physicians Select Ins C | NE | 0 | 0% | 0 | 0 | 0% |
| 1552 | Medica Ins Co | MN | 0 | 0% | 0 | 0 | 0% |
| 572 | NextBlue of ND Ins Co | ND | 0 | 0% | 0 | 0 | 0% |
| 1189 | Vision Serv Plan Ins Co | OH | 0 | 0% | 0 | 0 | 0% |
| 4794 | Clear Spring Hlth Ins C | AZ | 0 | 0% | 0 | 0 | 0% |
| | Elixir Ins Co | OH | 0 | 0% | 0 | 0 | 0% |

# 2025 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Lincoln Room, State Capitol

HB 1481
3/19/2025

Relating to dental insurer rate requirements; and to provide an effective date.

2:34 p.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

**Discussion Topics:**

- Federal Government Regulations
- Small business ownership
- Consumer protections

2:35 p.m. Chrystal Bartuska, ND Insurance Department, answered committee questions and submitted written testimony #43079.

2:44 p.m. Senator Roers moved amendment for addition of shall study.

2:45 p.m. Senator Lee seconded the motion.

| Senators | Vote |
|---|---|
| Senator Judy Lee | Y |
| Senator Kent Weston | N |
| Senator David A. Clemens | N |
| Senator Kathy Hogan | N |
| Senator Kristin Roers | Y |
| Senator Desiree Van Oosting | N |

Motion failed 2-4-0.

3:06 p.m. Chairman Lee closed the hearing.

*Andrew Ficek, Committee Clerk*

Sixty-ninth
Legislative Assembly
25.1250.03000 **ENGROSSED**

Sixty-ninth
Legislative Assembly
of North Dakota

**FIRST**

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 reporting and refund requirements; and to provide an effective date.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA**

~~**Dental insurer rates - Approval.**~~

~~1. 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 is less than seventy-five percent.~~

~~2. a. If the annual dental loss ratio for a dental benefit plan is less than 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 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. 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.~~

**SECTION 1. AMENDMENT** A new section to chapter 26.1-36.9-01 of the North Dakota Century Code is created and enacted as follows:

Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated by dividing the numerator by the denominator as determined under section 2 of this Act.

**SECTION 2. AMENDMENT** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Calculation of Dental Loss Ratio (DLR).**

1. The dental loss ratio is calculated by dividing the numerator by the denominator, where:

a. 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 at 45 CFR 158.140(a); and

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

**SECTION 3. AMENDMENT** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Transparency Reporting to Commissioner.**

1. A dental insurer that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Dental Loss Ratio (DLR) annual report with the Commissioner that is organized by market and product type and is filed in a manner prescribed by the commissioner.

2. The DLR reporting year shall be for the last calendar year for the dental benefit plans provided by the dental insurer and submitted to the Commissioner by April 30.

3. If data verification of the dental insurer representations in the DLR annual report is deemed necessary, the commissioner shall provide the dental insurer with a notification 30 days to submit any information required by the Commissioner.

4. After the Commissioner receives the dental loss ratio information collected pursuant to subsection 1 of this Section, the Commissioner shall make the information, including the aggregate dental loss ratio and other data reported, available to the public the departments website that allows members of the public to compare dental loss ratios among dental insurers by market type.

**SECTION 5. AMENDMENT** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Excess Revenue and Rebate**

1. If the annual dental loss ratio for a dental benefit insurer is less than seventy-five percent in the aggregate, the commissioner may require a dental insurer to refund the excess premium or provide premium credits to covered individuals and groups.
2. The commissioner may authorize a waiver or adjustment of subsection 1.

**SECTION 6. AMENDMENT** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Rule Making Authority.**

The Commissioner may adopt rules as necessary to effectuate the provisions of this section.

**Section 7. AMENDMENT EFFECTIVE DATE:** Section 5 of this Act becomes effective on July 1, 2027.

# 2025 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Lincoln Room, State Capitol

HB 1481
3/25/2025

| Relating to dental insurer rate requirements; and to provide an effective date. |
|---|

4:01 p.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

**Discussion Topics:**

- Large Group Insurance Plans
- Individual Insurance Market
- Employer Reimbursement Count

4:02 p.m. William Sherwin, Executive Director at The North Dakota Dental Association, answered committee questions and submitted testimony #43807.

4:17 p.m. Chairman Lee adjourned the meeting.

*Andrew Ficek, Committee Clerk*

25.1250.03005
Title.

Prepared by the Legislative Council staff for Senator Hogan
March 19, 2025

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~~two new ~~section~~sections to chapter 26.1-36.9 of the North Dakota Century Code, relating to dental insurer rate requirements and reporting; 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 commissioner ~~shall~~may 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 is less than seventy-five percent.
2. a. If the annual dental loss ratio for a dental benefit plan is less than 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 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. 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.** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Dental loss ratio transparency - Annual report to the commissioner.**

1. A dental insurer that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a dental loss ratio report with the commissioner by April thirtieth of each year, in a manner prescribed by the commissioner.

2. The dental loss ratio report must include dental loss ratio information for the last calendar year for a dental benefit plan provided by a dental insurer and be organized by market and product type.

3. The commissioner may request the dental insurer provide data verification of any information provided by the dental insurer in the dental loss ratio report. The dental insurer shall provide data verification to the commissioner within thirty days of the request.

4. The commissioner shall make the information provided in the dental loss ratio annual reports filed under this section available on the department's website, including the aggregate dental loss ratio, in a manner that allows the public to compare dental loss ratios among dental insurers by market type.

5. For purposes of this section, "dental loss ratio" has the same meaning as in section 1 of this Act.

**SECTION 3. EFFECTIVE DATE.** ~~This~~Section 1 of this Act becomes effective on ~~January~~July 1, 2027.

# 2025 SENATE STANDING COMMITTEE MINUTES

**Human Services Committee**
Fort Lincoln Room, State Capitol

HB 1481
3/26/2025

| |
|---|
| Relating to dental insurer rate requirements; and to provide an effective date. |

9:18 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

**Discussion Topics:**

- Prior Authorization Code
- Small Plan Exemptions
- Direct Reporting Procedure
- Data Collection
- Insurance Market Withdrawal

9:18 a.m. Chrystal Bartuska, Life/Health/Medicare Division Director with the North Dakota Insurance Department, answered committee questions.

9:32 a.m. William Sherwin, Executive Director, ND Dental Insurance Department, answered committee questions.

9:39 a.m. Dennis Pathroff, American Life Insurers, answered committee questions.

9:43 a.m. John Ward, Aflac Representative, answered committee questions.

10:09 a.m. Senator Hogan moved amendment LC#25.1250.03005.

10:09 a.m. Senator Van Oosting seconded the motion.

| Senators | Vote |
|---|---|
| Senator Judy Lee | Y |
| Senator Kent Weston | Y |
| Senator David A. Clemens | Y |
| Senator Kathy Hogan | Y |
| Senator Kristin Roers | Y |
| Senator Desiree Van Oosting | Y |

Motion passed 6-0-0.

10:11 a.m. Senator Hogan moved Do Pass as amended.

10:11 a.m. Senator Van Oosting seconded the motion.

| Senators | Vote |
|---|---|
| Senator Judy Lee | Y |
| Senator Kent Weston | Y |
| Senator David A. Clemens | N |
| Senator Kathy Hogan | Y |
| Senator Kristin Roers | N |
| Senator Desiree Van Oosting | Y |

Motion passed 4-2-0

Senator Van Oosting will carry the bill.

10:16 a.m. Chairman Lee closed the hearing.

*Andrew Ficek, Committee Clerk*

Prepared by the Legislative Council staff for Senator Hogan
March 19, 2025

3/26/25 VC
1 of 4

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~~two new ~~section~~sections to chapter 26.1-36.9 of the North Dakota Century Code, relating to dental insurer rate requirements and reporting; 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 commissioner ~~shall~~may 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 is less than seventy-five percent.
2. a. If the annual dental loss ratio for a dental benefit plan is less than 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 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. 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.** A new section to chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

**Dental loss ratio transparency - Annual report to the commissioner.**

1. A dental insurer that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a dental loss ratio report with the commissioner by April thirtieth of each year, in a manner prescribed by the commissioner.

2. The dental loss ratio report must include dental loss ratio information for the last calendar year for a dental benefit plan provided by a dental insurer and be organized by market and product type.

3. The commissioner may request the dental insurer provide data verification of any information provided by the dental insurer in the dental loss ratio report. The dental insurer shall provide data verification to the commissioner within thirty days of the request.

4. The commissioner shall make the information provided in the dental loss ratio annual reports filed under this section available on the department's website, including the aggregate dental loss ratio, in a manner that allows the public to compare dental loss ratios among dental insurers by market type.

5. For purposes of this section, "dental loss ratio" has the same meaning as in section 1 of this Act.

**SECTION 3. EFFECTIVE DATE.** ~~This~~Section 1 of this Act becomes effective on ~~January~~July 1, 2027.

# REPORT OF STANDING COMMITTEE
# ENGROSSED HB 1481

**Human Services Committee (Sen. Lee, Chairman)** recommends **AMENDMENTS (25.1250.03005)** and when so amended, recommends **DO PASS** (4 YEAS, 2 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1481 was placed on the Sixth order on the calendar. This bill does not affect workforce development.