SB203

HGG9B68-1

By Senator Shelnutt

RFD: Banking and Insurance

First Read: 27-Feb-25

SYNOPSIS:

The law does not currently regulate how insurers that cover dental care spend the premiums received from individuals and groups that contract for dental care payment or reimbursement.

This bill would require dental insurers to spend at least 85 percent of the premiums they receive on customer claims. Dental insurers that fail to spend at least 85 percent of premiums on claims would be required to refund the excess premiums retained to policyholders.

This bill would further require dental insurers to report certain income and expense information to the Commissioner of Insurance on an annual basis, and make it available to the public.

This bill would also require the Commissioner of Insurance to disallow proposed rate increases by dental insurers that exceed the consumer price index for dental services, and would provide an opportunity for a hearing if the insurer seeks to reverse the commissioner's decision.

A BILL

TO BE ENTITLED

AN ACT

Relating to dental insurance; to establish a medical loss ratio as a percentage of premiums collected by an insurer; to require reporting of the insurer's claims expenses and income information for compliance with the medical loss ratio; to require an insurer to give a rebate to enrollees if payments on claims are below the medical loss ratio; to provide for disclosure of insurer financial information; to prohibit excessive increases in premiums; and to amend Sections 10A-20-6.16 and 27-21A-23, Code of Alabama 1975, to make conforming changes.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. (a) For the purposes of this section, the following terms have the following meanings:

(1) COMMISSIONER. The Commissioner of Insurance.

(2) DENTAL BENEFIT PLAN. Any stand-alone individual or group plan, policy, or contract issued, delivered, or renewed in this state which is limited to paying or reimbursing the costs of dental care services.

(3) DENTAL CARE SERVICES. Any services furnished to an individual for the purpose of preventing, managing, alleviating, curing, or healing dental illness or injury as indicated by codes used for payment or reimbursement by the insurer.

(4) HEALTH BENEFIT PLAN. a. Any individual or group plan, policy, or contract issued, delivered, or renewed in this state that, in addition to paying or reimbursing for

hospitalization, physician care, treatment, surgery, therapy, drugs, equipment, and other medical expenses, also includes coverage for some dental care services.

b. The term does not include accident-only, specified disease, individual hospital indemnity, credit, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies, or coverage issued as supplemental to liability insurance, workers' compensation, or automobile medical payment insurance.

(5) INSURER. A person as defined in Section 27-1-2, Code of Alabama 1975, which issues, delivers, or renews a dental benefit plan or a health benefit plan.

(6) MEDICAL LOSS RATIO. The percentage of premiums collected by an insurer from policyholders or subscribers which the insurer spends on dental care services for patients.

(7) REPORTING YEAR. A calendar year.

(b)(1) The minimum medical loss ratio for dental benefit plans and health benefit plans in this state shall be 85 percent, to be calculated pursuant to subdivisions (2) through (4).

(2) The percentage is a fraction of which the numerator is the aggregated claims paid for dental care services by the insurer in a reporting year, and the denominator is the amount of all premiums collected by the insurer in a reporting year.

(3)a. The aggregated claims paid by the insurer for dental care services shall be calculated by:

1. Adding the amount paid or reimbursed on claims for dental care services; then

2. Adding the amount of reserves and liabilities for claims received during the reporting year but unpaid or not reimbursed within three months after the end of the reporting year; then

3. Subtracting any amount expended for dental care services that was recovered due to overpayment or utilization management.

b. The amount of all premiums collected by the insurer shall be calculated by:

1. Including the total amount of money received from policyholders or subscribers as a condition of receiving coverage for dental care services; then

2. Subtracting payments for federal and state taxes, licensing, and regulatory fees; then

3. Including any net addition or subtraction resulting from payments or receipts for risk adjustment, risk corridors, or reinsurance.

(4) The insurer's overhead expenses, to include all of the following components, shall be excluded from the calculations made under subdivision (3):

a. Financial administration expenses, including underwriting, auditing, actuarial analyses, treasury, and investment expenses.

b. Marketing, sales, and distribution expenses, including advertising; group, policyholder, or subscriber enrollment and relations, regardless of whether these activities are performed by the carrier or outsourced to a third-party vendor.

c. Distribution expenses, including commissions, and relations with agents, producers, brokers, and benefit consultants.

d. Claims operation expenses, including adjudication, appeals, settlements, claims payment processing, and costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims.

e. Dental administration expenses, including activities related to care and disease management, utilization review, dental management, network development, secondary network savings, administrative fees, claims processing, utilization management, fraud prevention activities, and provider credentialing expenses, regardless of whether these activities are performed by the carrier or outsourced to a third-party vendor.

f. Provider expenses, such as consultants for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee.

g. Expenses incurred for developing and executing provider contracts, including fees associated with establishing or managing a provider network, and fees paid to vendors, costs of stop-loss coverage or reinsurance, direct sales salaries, workforce salaries and benefits, agents and broker fees and commissions, and general and administrative expenses.

h. Network operational expenses, including contracting, dentist relations, and dental policy procedures.

i. Charitable expenses, including any contributions to tax-exempt foundations and community benefits.

j. Industry association expenses, including membership activities.

k. Employee and personnel expenses, including payroll, recruitment, and human resources.

l. Physical plant expenses, including construction, leasing, maintenance, cleaning, furniture, and equipment.

m. Third-party vendor and professional contractor expenses, including related services or goods required under paragraphs a. through l.

(c)(1) No later than March 31, an insurer shall file a report with the commissioner which shall include all of the following information for the previous reporting year:

a. All dental care services and products offered by the insurer, identifying each individual and group dental benefit plan or health benefit plan, with the number of individuals enrolled under each plan.

b. Gross income, including gross premiums collected by the insurer.

c. Medical loss ratio.

d. The aggregated claims paid by the insurer for dental care services, including each amount required under subparagraphs (b)(3)a.1. through 3.

e. The amount of premiums collected by the insurer, including each amount required under subparagraphs (b)(3)b.1.

through 3.

f. Overhead expenses, presenting each amount required under paragraphs (b)(4)a. through m.

g. Realized capital gains and losses.

h. Net income.

i. Accumulated surplus.

j. Accumulated reserves.

k. Risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners.

(2) The commissioner shall make available to the public the information submitted by the insurer pursuant to subdivision (1) by posting the information on the website of the Department of Insurance of the State of Alabama.

(3)a. If the commissioner has reasonable cause to believe that the information submitted by the insurer pursuant to subdivision (1) is erroneous or false, the commissioner may conduct an examination of the insurer to verify the information submitted according to the procedures provided under Article 1 of Chapter 2 of Title 27, Code of Alabama 1975.

b. The provisions of Article 1 of Chapter 2 of Title 27, Code of Alabama 1975, including confidentiality of information, remedies, and procedures available to both the commissioner and the insurer, shall govern an examination conducted pursuant to paragraph a.

(d)(1) If the report required by subsection (c), as submitted by the insurer or as adjusted by the commissioner

upon an examination as provided in that subsection, shows that the medical loss ratio for the reporting year is less than 85 percent, the insurer shall refund the excess premium collected to the covered individuals or groups as a rebate.

(2) The total amount of the rebate shall equal the amount by which the medical loss ratio authorized by subdivision (b)(1) exceeds the insurer's reported medical loss ratio, multiplied by the amount of all premiums collected by the insurer as calculated under paragraph (b)(3)b.

(3) Within 30 days of the calculation of the rebate, the insurer shall notify all individuals and groups that were covered under the applicable reporting year that they qualify for the refund, which may be paid directly to the individuals and groups or issued as a credit on the premium for the subsequent reporting year.

(e)(1) Insurers shall file with the commissioner proposed premium rates or any changes to rating factors that are to take effect on January 1, on or before July 1 of the preceding year.

(2)a. The commissioner shall disapprove: (i) any proposed premium rates that are excessive, inadequate, or unreasonable in relation to the dental care services provided under the dental benefit plan or the health benefit plan; and (ii) any proposed change to rating factors that is discriminatory or actuarially unsound.

b. A proposed premium rate is presumptively excessive if any of the following apply:

1. The premium rate adjustment increases by more than

the most recent calendar year's percentage increase in the dental services consumer price index, U.S. city average.

2. The insurer's reported contribution to surplus exceeds 1.9 percent.

3. The aggregate medical loss ratio for all plans paying or reimbursing for dental care services offered by the insurer is less than 85 percent.

(3) If the commissioner disapproves a submission made pursuant to subdivision (1), the commissioner shall notify the insurer no later than October 1, and the insurer may request a hearing to reverse or modify the commissioner's decision, which shall be conducted according to the notice, hearing, and appeal procedures as provided under Article 1 of Chapter 2 of Title 27, Code of Alabama 1975.

(4) For any hearing conducted pursuant to subdivision (3) concerning a proposed premium rate increase, the following requirements shall be met:

a. The insurer shall notify the policyholders or subscribers who would be affected by the increase that it is requesting a hearing to reverse or modify the commissioner's decision.

b. Public notice pursuant to Section 27-2-29, Code of Alabama 1975, shall also be given by the commissioner to the policyholders or subscribers, as individuals whose pecuniary interests are to be directly and immediately affected in case of an order reversing or modifying the commissioner's decision.

c. Opportunity shall be given by the commissioner for

at least three policyholders or subscribers to testify at the hearing concerning the impact of reversing or modifying the commissioner's decision, which testimony shall be made a part of the record.

(f) The commissioner shall adopt rules, forms, and schedules necessary to implement and enforce this section.

Section 2. Sections 10A-20-6.16 and 27-21A-23, Code of Alabama 1975, are amended to read as follows:

"§10A-20-6.16

(a) No statute of this state applying to insurance companies shall be applicable to any corporation organized under this article and amendments thereto or to any contract made by the corporation; except the corporation shall be subject to the following:

(1) The provisions regarding annual premium tax to be paid by insurers on insurance premiums.

(2) Chapter 55 of Title 27.

(3) Article 2 and Article 3 of Chapter 19 of Title 27.

(4) Section 27-1-17.

(5) Chapter 56 of Title 27.

(6) Rules adopted by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

(7) Chapter 54 of Title 27.

(8) Chapter 57 of Title 27.

(9) Chapter 58 of Title 27.

(10) Chapter 59 of Title 27.

(11) Chapter 54A of Title 27.

(12) Chapter 12A of Title 27.

(13) Chapter 2B of Title 27.

(14) Chapter 29 of Title 27.

(15) Chapter 62 of Title 27.

(16) Chapter 63 of Title 27.

(17) Chapter 45A of Title 27.

(18) Section 1 of the act amending this section.

(b) The provisions in subsection (a) that require specific types of coverage to be offered or provided shall not apply when the corporation is administering a self-funded benefit plan or similar plan, fund, or program that it does not insure."

"§27-21A-23

(a) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of health care service plan laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or health care service plan licensed and regulated pursuant to the insurance law or the health care service plan laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing

medicine and shall be exempt from the provisions of Section 34-24-310, et seq., relating to the practice of medicine.

(d) No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance, or malpractice in connection with the furnishing of such services and supplies.

(e) Nothing in this chapter shall be construed in any way to repeal or conflict with any provision of the certificate of need law.

(f) Notwithstanding the provisions of subsection (a), a health maintenance organization shall be subject to all of the following:

(1) Section 27-1-17.

(2) Chapter 56.

(3) Chapter 54.

(4) Chapter 57.

(5) Chapter 58.

(6) Chapter 59.

(7) Rules adopted by the Commissioner of Insurance pursuant to Sections 27-7-43 and 27-7-44.

(8) Chapter 12A.

(9) Chapter 54A.

(10) Chapter 2B.

(11) Chapter 29.

(12) Chapter 62.

(13) Chapter 63.

(14) Chapter 45A

(15) Section 1 of the act amending this section."

Section 3. This act shall become effective on October 1, 2025.