

SENATE BILL NO. 335

INTRODUCED BY G. HERTZ

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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21 **NEW SECTION. Section 3. Transparency of dental insurance premiums.** (1) A dental insurer that
22 issues, sells, or renews a plan, policy, contract, or certificate covering dental services shall file by March 1 of
23 each year with its annual statement a medical dental loss ratio report with the commissioner of securities and
24 insurance that is organized by market and product type and contains similar information required in the 2013
25 federal medical loss ratio annual reporting form. The filing must also report additional data that includes the
26 number of enrollees, the annual maximum coverage limit, and the number of enrollees who meet or exceed the
27 annual coverage limit.

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

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

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

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

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

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

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

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

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19 **NEW SECTION. Section 4. Excess revenue -- rebate to policyholders and certificate holders.**

20 (1) (a) (i) A dental insurer that issues, sells, or renews a plan, policy, contract, or certificate covering dental
21 services shall provide an annual rebate or credit to each policyholder or certificate holder:

22 (A) whether individual or part of a group;

23 (B) on a pro rata basis; and

24 (C) if the ratio of the amount of premium revenue expended by the dental insurer on the costs for
25 reimbursement for services provided to policyholders or certificate holders to the total amount of premium
26 revenue, as reported in [section 3], is less than 80%.

27 (ii) The cost of activities that improve dental care quality may be added to the costs for
28 reimbursement in the calculation.

1 (b) The total amount of premium revenue must exclude federal and state taxes and licensing or
2 regulatory fees.

3 (c) The total amount of an annual rebate required under this section must equal the product of the
4 amount by which the percentage in (1)(a)(i)(C) exceeds the insurer's reported percentage in [section 3]
5 multiplied by the annual premium revenue less federal and state taxes and licensing or regulatory fees.

6 (2) A dental insurer shall provide any rebate owing to a policyholder or certificate holder no later
7 than August 1 of the calendar year following the year for which the ratio described in subsection (1) is
8 calculated.

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

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

13 (i) expenditures for clinical dental services;

14 (ii) activities that improve dental care quality; and

15 (iii) overhead and administrative cost expenditures.

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

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

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

23 **"33-18-208. Contract to contain agreements -- rebates prohibited -- life, disability, and annuity**

24 **contracts.** Except as otherwise expressly provided by law and in [section 4], no a person shall may not
25 knowingly:

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

28 (2) pay or allow or give or offer to pay, allow, or give, directly or indirectly, as inducement to such

1 insurance or annuity any rebate of premiums payable on the contract or any special favor or advantage in the
 2 dividends or other benefits thereon or any paid employment or contract for services of any kind or any valuable
 3 consideration or inducement whatever not specified in the contract;

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

9 (4) offer, promise, or give anything of value whatsoever not specified in the contract."
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11 NEW SECTION. Section 7. Codification instruction. [Sections 1 through 5] are intended to be
 12 codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections
 13 1 through 5].
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15 NEW SECTION. Section 8. Effective date. [This act] is effective June 1, 2025.
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17 NEW SECTION. Section 9. Applicability. [This act] applies to dental insurance policies, plans,
 18 contracts, and certificates issued or renewed on or after January 1, 2026.
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