Rep. Jennifer Gong-Gershowitz

Filed: 4/20/2023

AMENDMENT TO SENATE BILL 1289

AMENDMENT NO. _____. Amend Senate Bill 1289 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be referred to as the Dental Loss Ratio Act.

Section 5. Definitions. As used in this Act:

"Dental care provider" means a dentist who bills for services in Illinois.

"Dental loss ratio" means the ratio of incurred claims to earned premiums as calculated using the formula under Section 10 of this Act.

"Dental plan carrier" means an entity subject to the insurance laws, rules, and regulations of this State or subject to the jurisdiction of the Director that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of dental care services,

including an accident and health insurance company, a health maintenance organization, a limited health service organization, a dental service plan corporation, a health services plan corporation, a voluntary health services plan, or any other entity providing a plan of dental insurance, dental benefits, or dental health care services.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Earned premiums" means the portion of the premium paid in the reporting year that is intended to provide coverage during that reporting period.

"Incurred claims" means the claims for which services were provided in that reporting year. "Incurred claims" includes claims that were paid in the reporting year plus unpaid claim reserves for claims paid after the reporting year.

Section 10. Dental loss ratio reporting.

(a) A health insurer or dental plan carrier that issues, sells, renews, or offers a specialized health insurance policy covering dental services shall, beginning January 1, 2024, annually submit to the Department the dental loss ratio calculated in accordance with subsection (c). The annual filing shall, at a minimum, include rates, rating schedules, and supporting documentation, including ratios of incurred claims to earned premiums for each calendar year since the plan's issuance. The required information shall be in the form

established by the Department and shall demonstrate that each plan complies with the minimum dental loss ratio standards.

(b) The annual filing shall be made publicly available on the Department's website.

(c) The dental loss ratio for a dental plan or dental coverage of a health benefit plan shall be determined by dividing the numerator by the denominator as follows:

(1) The numerator is the amount spent on dental care. The amount spent on dental care shall include:

(A) the amount expended for clinical dental services that are services within the Code on Dental Procedures and Nomenclature, provided to enrollees that includes payments under capitation contracts with dental providers, and covered by the contract for dental clinical services or supplies covered by the contract;

(B) reserves and liabilities established to account for claims that were incurred during the reporting year but were not paid within 3 months of the end of the reporting year; and

(C) any claim payment recovered by insurers from providers or enrollees using utilization management efforts, but which shall be deducted from incurred claims amounts.

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

(A) any overpayment that has already been received

from providers that should not be reported as a paid claim; overpayment recoveries received from providers must be deducted from incurred claims amounts;

(B) all administrative costs, including, but not limited to, infrastructure, personnel costs, or broker payments;

(C) amounts paid to third-party vendors for secondary network savings;

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

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

(3) 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. In this paragraph, "earned premium revenues" means all moneys 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 plan.

(d) If the Director decides to conduct an examination because the Director finds it necessary to verify a health insurer's or dental plan carrier's representation in a dental loss ratio report, then the Department shall provide the health insurer or dental plan carrier with a notification 30 days before the commencement of the examination.

(e) The health insurer or dental plan carrier shall have 30 days after the date of notification to electronically submit to the Department all requested records specified by the Department. The Director may extend the time for a health insurer or dental plan carrier to comply with this examination upon a finding of good cause.

Section 15. Dental loss ratio requirement.

(a) A health insurer or dental plan carrier that issues, sells, renews, or offers a specialized health insurance policy covering dental services shall meet a minimum dental loss ratio requirement of 80%.

(b) If the minimum dental loss ratio is not met, then the Department shall require a corrective action plan from the carrier to return excess premiums.

Section 20. Rulemaking. The Department may adopt rules to implement this Act.

Section 25. Exemptions. This Act does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided as a function of the State of Illinois Medicaid coverage for children or adults or disability insurance for covered benefits in the single specialized area of dental-only health care that pays benefits on a fixed benefit, cash payment-only basis.

Section 90. The Illinois Insurance Code is amended by adding Section 355.5 as follows:

(215 ILCS 5/355.5 new)

Sec. 355.5. Dental coverage reimbursement; prohibitions. No insurer, dental service plan corporation, professional service corporation, insurance network leasing company, or any company that amends, delivers, issues, or renews an individual or group policy of accident and health insurance on or after the effective date of this amendatory Act of the 103rd General Assembly shall require a dental care provider to incur a fee to access and obtain payment or reimbursement for services provided. A dental plan carrier shall provide a dental care provider with 100% of the contracted amount of the payment or reimbursement. Fees incurred directly by a dental care provider from third parties related to transmitting an automated clearinghouse network claim, transaction management,

data management, or portal services and other fees charged by third parties that are not in the control of the dental plan carrier shall not be prohibited by this Section.

Section 95. The Dental Service Plan Act is amended by changing Sections 25 and 34 as follows:

(215 ILCS 110/25) (from Ch. 32, par. 690.25)

Sec. 25. Application of Insurance Code provisions. Dental service plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA, VIII 1/2, XI, and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 355.2, 355.3, 367.2, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and subsection (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 99-151, eff. 7-28-15.)

(215 ILCS 110/34) (from Ch. 32, par. 690.34)

Sec. 34. No such corporation shall disburse during any one year~~, except upon the approval of the Director,~~ a sum greater than 20% of payments received from subscribers during that year, as administrative expenses.

The term "administrative expense" as used in this Section ~~section~~ includes all expenditures for nonprofessional services and in general all expenses not directly connected with the payment for dental services, but does not include expenses of

soliciting subscriptions.

(Source: Laws 1965, p. 2179.)

Section 99. Effective date. This Act takes effect January 1, 2024.".