SENATE BILL 23-179

BY SENATOR(S) Moreno and Will, Buckner, Coleman, Cutter, Exum, Gonzales, Hansen, Hinrichsen, Jaquez Lewis, Marchman, Mullica, Priola; also REPRESENTATIVE(S) Hartsook and Daugherty, Amabile, Bird, Boesenecker, Brown, deGruy Kennedy, Dickson, Gonzales-Gutierrez, Hamrick, Jodeh, Lindsay, Marshall, Michaelson Jenet, Ricks, Weissman, Willford, Young, McCluskie.

CONCERNING INSURANCE CARRIER REQUIREMENTS FOR HEALTH COVERAGE PLANS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Access to quality dental care is an essential component of every Coloradan's health and well-being, as untreated dental issues contribute to a number of serious medical conditions, including chronic obstructive pulmonary disease, heart disease, stroke, and preterm labor or premature birth, all of which drastically increase costs to individuals and to the state;

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(b) Meaningful insurance coverage is one of the most important factors behind patients utilizing dental care services;

(c) Greater transparency on how premium dollars are spent by health insurance carriers provides accountability for insurance plans and ensures that patients get the most value for premiums paid;

(d) Patients should have visibility regarding how many of their insurance premium dollars pay for health-care and dental services as opposed to administrative, marketing, and operational costs;

(e) Medical loss ratio standards have been in place for health insurance for more than 10 years;

(f) Dental plans in this state are not required to have equivalent transparency and disclosure standards, known as dental loss ratios, in place;

(g) When patients and employers are comparing dental plans for purchase, they should have access to information that shows how much coverage is actually provided relative to what they pay in premiums for the coverage;

(h) Bringing transparency to how much care the premiums are actually paying for is an important step to drive efficiencies in care and ensure value in patients' dental benefits; and

(i) As Colorado has long been a leader in policies that increase transparency, value, accountability, and access to health care for consumers, Colorado should continue to lead and provide protections for consumers in accessing dental care coverage.

(2) In order to ensure dental care is accessible for all Coloradans, it is critical that Colorado establish transparency and accountability for dental plans.

SECTION 2. In Colorado Revised Statutes, 10-16-107, **amend** (1)(a), (1)(f), (2)(a)(I) introductory portion, and (2)(b) as follows:

10-16-107. Rate filing regulation - benefits ratio - rules. (1) (a) A carrier subject to part 2, 3, ~~or~~ 4, OR 5 of this ~~article~~ ARTICLE 16 shall not

establish rates for any sickness, accident, or health insurance policy, contract, certificate, or other evidence of coverage OR DENTAL COVERAGE PLAN, AS DEFINED IN SECTION 10-16-165 (1)(a), issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado that are excessive, inadequate, or unfairly discriminatory. To assure compliance with the requirements of this section that rates are not excessive in relation to benefits, the commissioner shall promulgate rules to require rate filings and, as part of the rules, may require the submission of adequate documentation and supporting information, including actuarial opinions or certifications and set expected benefits ratios. The carrier shall submit expected rate increases to the commissioner at least sixty days prior to the proposed implementation of the rates. If the commissioner does not approve or disapprove the rate filings within a sixty-day period, the carrier may implement and reasonably rely upon the rates on the condition that the commissioner may require correction of any deficiencies in the rate filing upon later review if the rate the carrier charged is excessive, inadequate, or unfairly discriminatory. A prospective rate adjustment is the sole remedy for rate deficiencies pursuant to this subsection (1). If the commissioner finds deficiencies in the rate filing after a sixty-day period, the commissioner shall provide notice to the carrier, and the carrier shall correct the rate on a prospective basis.

(f) Carriers shall file rate filings for insurance regulated under parts 1 to ~~4~~ ***5*** of this ~~article~~ ARTICLE 16 electronically in a format made available by the division, unless exempted by rule for an emergency situation as determined by the commissioner. The division shall post on its website a rate filing summary for insurance regulated under parts 1 to ~~4~~ ***5*** of this ~~article~~ ARTICLE 16 in order to provide notice to the public.

(2) (a) (I) Rates for an individual health coverage plan issued or delivered to any policyholder, enrollee, subscriber, or member in Colorado by an insurer subject to part 2 of this article 16 or an entity subject to part 3, ~~or~~ 4, OR 5 of this article 16 shall not be excessive, inadequate, or unfairly discriminatory to assure compliance with the requirements of this section that rates are not excessive in relation to benefits. Rates are excessive if they are likely to produce a long run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered. In determining if rates are excessive, the commissioner may consider:

(b) Notwithstanding any other provision of this ~~article~~ ARTICLE 16, a carrier subject to part 2, 3, ~~or~~ 4, OR 5 of this ~~article~~ ARTICLE 16 shall not vary the premium rate for an individual health coverage plan due to the gender of the individual policyholder, enrollee, subscriber, or member. Any premium rate based on the gender of the individual policyholder, enrollee, subscriber, or member is unfairly discriminatory and is not allowed.

SECTION 3. In Colorado Revised Statutes, **add** 10-16-165 as follows:

10-16-165. Dental coverage plans - dental loss ratio - rules - definitions. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "COMMUNITY BENEFIT EXPENDITURE" MEANS AN EXPENDITURE FOR AN ACTIVITY OR PROGRAM, OR TO AN ORGANIZATION, WHICH SEEKS TO ACHIEVE THE OBJECTIVES OF IMPROVING ACCESS TO DENTAL SERVICES AND ENHANCING DENTAL PUBLIC HEALTH. THIS INCLUDES AN ACTIVITY THAT:

(I) IS AVAILABLE BROADLY TO THE PUBLIC AND SERVES LOW-INCOME CONSUMERS;

(II) REDUCES GEOGRAPHIC, FINANCIAL, OR CULTURAL BARRIERS TO ACCESSING DENTAL SERVICES, AND IF THE ACTIVITY CEASED TO EXIST WOULD RESULT IN ACCESS PROBLEMS;

(III) ADDRESSES ORAL HEALTH WORKFORCE SHORTAGES, SUCH AS ADVANCING EDUCATION AND TRAINING OF ORAL HEALTH PROFESSIONALS; OR

(IV) LEVERAGES OR ENHANCES DENTAL PUBLIC HEALTH ACTIVITIES.

(b) "DENTAL COVERAGE PLAN" MEANS A HEALTH COVERAGE PLAN THAT INCLUDES COVERAGE FOR THE COSTS OF DENTAL CARE SERVICES. "DENTAL COVERAGE PLAN" INCLUDES A PLAN ISSUED BY A PREPAID DENTAL PLAN ORGANIZATION THAT HAS A CERTIFICATE OF AUTHORITY TO OPERATE PURSUANT TO PART 5 OF THIS ARTICLE 16.

(c) (I) "DENTAL LOSS RATIO" MEANS THE PERCENTAGE OF PREMIUM DOLLARS COLLECTED EACH YEAR FOR A DENTAL COVERAGE PLAN THAT THE

DENTAL COVERAGE PLAN INCURS ON DENTAL SERVICES PROVIDED TO AN ENROLLEE, SEPARATE FROM OVERHEAD AND ADMINISTRATIVE COSTS.

(II) 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 THE AMOUNT OF CLAIMS PAYMENTS IDENTIFIED THROUGH FRAUD REDUCTION EFFORTS; AND

(B) THE DENOMINATOR IS THE TOTAL AMOUNT OF PREMIUM REVENUE, EXCLUDING FEDERAL AND STATE TAXES, LICENSING AND REGULATORY FEES PAID, NONPROFIT COMMUNITY BENEFIT EXPENDITURES, AND ANY OTHER PAYMENTS REQUIRED BY FEDERAL LAW.

(2) (a) THE COMMISSIONER SHALL DEFINE BY RULE:

(I) EXPENDITURES FOR CLINICAL DENTAL SERVICES;

(II) ACTIVITIES THAT IMPROVE DENTAL CARE QUALITY;

(III) OVERHEAD AND ADMINISTRATIVE COST EXPENDITURES; AND

(IV) NONPROFIT COMMUNITY BENEFIT EXPENDITURES THAT ARE ALIGNED WITH EXCLUSION PARAMETERS AND LIMITS OUTLINED IN 45 CFR 158.162; EXCEPT THAT THE COMMISSIONER SHALL ENSURE THAT ONLY EXPENDITURES THAT IMPROVE ACCESS TO DENTAL SERVICES OR ENHANCE DENTAL HEALTH, AND NO OVERHEAD OR ADMINISTRATIVE COSTS, ARE REPORTED UNDER THIS SECTION.

(b) 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 AS DESCRIBED IN SUBSECTION (1)(b)(II)(A) OF THIS SECTION.

(3) (a) ON OR BEFORE JULY 31, 2024, AND ON OR BEFORE JULY 31

EACH YEAR THEREAFTER, A CARRIER THAT ISSUES, SELLS, RENEWS, OR OFFERS A DENTAL COVERAGE PLAN SHALL FILE A DENTAL LOSS RATIO FORM ELECTRONICALLY WITH THE DIVISION FOR THE PRECEDING CALENDAR YEAR IN WHICH DENTAL COVERAGE WAS PROVIDED BY THE DENTAL COVERAGE PLAN. THE COMMISSIONER MAY CREATE A NEW REPORTING FORM OR USE AN EXISTING REPORTING FORM TO FACILITATE DATA COLLECTION. THE COMMISSIONER SHALL ENSURE THAT FIELDS ARE REPORTED CONSISTENTLY BY CARRIERS. THE FILING MUST:

(I) REPORT THE CALCULATED DENTAL LOSS RATIO ACCORDING TO THE FORMULA IN SUBSECTION (1)(b)(II) OF THIS SECTION;

(II) SEPARATELY REPORT EACH DATA ELEMENT DESCRIBED IN SUBSECTION (1)(b) OF THIS SECTION;

(III) 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;

(IV) REPORT DATA BY MARKET SEGMENT AND PRODUCT TYPE, AS DEFINED BY RULE OF THE COMMISSIONER; AND

(V) BE IN A FORM AND MANNER AS PRESCRIBED BY RULE OF THE COMMISSIONER.

(b) FOR THE REPORT TO BE SUBMITTED ON OR BEFORE JULY 31, 2024, A CARRIER SHALL ALSO SUBMIT THE INFORMATION REQUIRED IN SUBSECTION (3)(a) OF THIS SECTION FOR THE PLAN YEARS 2021 THROUGH 2024.

(c) IF THE COMMISSIONER DEEMS THAT DATA VERIFICATION OF A CARRIER'S DENTAL LOSS RATIO FOR A DENTAL COVERAGE PLAN IS NECESSARY, THE COMMISSIONER SHALL GIVE THE CARRIER AT LEAST THIRTY DAYS NOTIFICATION PRIOR TO BEGINNING THE VERIFICATION PROCESS WITH THE CARRIER.

(d) (I) BY JANUARY 1 OF THE YEAR AFTER THE DIVISION RECEIVES THE DENTAL LOSS RATIO INFORMATION COLLECTED PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION, THE DIVISION SHALL MAKE THE INFORMATION, INCLUDING THE AGGREGATE DENTAL LOSS RATIO AND THE