REFERENCE TITLE: dental insurance; medical loss ratio

State of Arizona
Senate
Fifty-sixth Legislature
First Regular Session
2023

SB 1302

Introduced by
Senator Kavanagh

AN ACT

AMENDING SECTIONS 20-847, 20-1057.12, 20-1342.06, 20-1402.04 AND 20-1404.04, ARIZONA REVISED STATUTES; RELATING TO DENTAL INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-847, Arizona Revised Statutes, is amended to read:

20-847. Contracts; dentists; covered services; medical loss ratio report; rebate; rates and rating factors; definitions

A. A contract~~,~~ entered into or renewed ~~on or after January 1, 2011,~~ between a dental service corporation and a dentist who is licensed to practice in this state shall not require the dentist to provide ~~services~~ A SERVICE to an individual covered under a subscription contract based on a fee set by the dental service corporation unless the service for which the fee applies is a covered service under the individual's subscription contract.

B. BOTH OF THE FOLLOWING APPLY TO A DENTAL SERVICE CORPORATION THAT OFFERS, ISSUES OR RENEWS A SUBSCRIPTION CONTRACT COVERING DENTAL SERVICES:

1. ON OR BEFORE MARCH 31 OF EACH YEAR, THE DENTAL SERVICE CORPORATION SHALL FILE WITH THE DEPARTMENT A MEDICAL LOSS RATIO REPORT THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE. THE MEDICAL LOSS RATIO REPORTING YEAR IS THE CALENDAR YEAR DURING WHICH DENTAL COVERAGE IS PROVIDED BY THE SUBSCRIPTION CONTRACT. ALL TERMS USED IN THE MEDICAL LOSS RATIO REPORT SHALL HAVE THE SAME MEANINGS PRESCRIBED IN THE PUBLIC HEALTH SERVICE ACT (45 CODE OF FEDERAL REGULATIONS PART 158). THE MEDICAL LOSS RATIO REPORT SHALL CONTAIN THE FOLLOWING INFORMATION:

(a) THE COMPANY NAME.

(b) THE GROUP AFFILIATION.

(c) THE FEDERAL EMPLOYMENT IDENTIFICATION NUMBER.

(d) THE BEST CONTACT TELEPHONE NUMBER IN THE DAY TIME.

(e) THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS GROUP CODE.

(f) THE DOING BUSINESS AS NAME.

(g) THE ISSUER IDENTIFICATION NUMBER.

(h) BUSINESS, IN WHAT STATE.

(i) THE DOMICILIARY STATE.

(j) THE ADDRESS.

(k) THE FEDERAL TAX EXEMPT NUMBER.

(l) THE MARKETPLACE.

(m) THE MERGE MARKETS.

(n) THE NONPROFIT NUMBER.

(o) THE MEDICAL LOSS RATIO REPORTING YEAR.

2. IF DATA VERIFICATION OF A MEDICAL LOSS RATIO REPORT IS DEEMED NECESSARY, THE DEPARTMENT SHALL NOTIFY THE DENTAL SERVICE CORPORATION AT LEAST THIRTY DAYS BEFORE BEGINNING ANY FINANCIAL EXAMINATION. THE DENTAL SERVICE CORPORATION SHALL SUBMIT ALL REQUESTED DATA TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE NOTICE. ON A FINDING OF GOOD CAUSE, THE DEPARTMENT MAY EXTEND THE TIME FOR A DENTAL SERVICE CORPORATION TO COMPLY WITH THIS PARAGRAPH.

C. THE DEPARTMENT SHALL MAKE AVAILABLE TO THE PUBLIC THE MEDICAL LOSS RATIO REPORT AND ALL DATA PROVIDED BY A DENTAL SERVICE CORPORATION PURSUANT TO SUBSECTION B OF THIS SECTION.

D. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A DENTAL SERVICE CORPORATION THAT PROVIDES SERVICES UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 4 OR THIS STATE'S HEALTH AND ACCIDENT INSURANCE PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 4.

E. A DENTAL SERVICE CORPORATION OWES A REBATE TO SUBSCRIBERS ON A PRO RATA BASIS BY AUGUST 1 FOLLOWING THE CALENDAR YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS FILED IF THE MEDICAL LOSS RATIO:

1. FOR A LARGE GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY-FIVE PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY-FIVE PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

2. FOR A SMALL GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

F. A DENTAL SERVICE CORPORATION SHALL FILE GROUP PRODUCT BASE RATES AND ANY CHANGES TO THE GROUP RATING FACTORS THAT ARE TO BECOME EFFECTIVE JANUARY 1 OF EACH CALENDAR YEAR ON OR BEFORE JULY 1 OF THE PRECEDING YEAR. IF THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS ARE EXCESSIVE, INADEQUATE OR UNREASONABLE IN RELATION TO THE BENEFITS CHARGED OR ARE DISCRIMINATORY OR NOT ACTUARILY SOUND, THE DEPARTMENT SHALL DENY THE GROUP PRODUCT BASE RATES OR GROUP RATING FACTORS.

G. THE DEPARTMENT SHALL PRESUMPTIVELY DENY THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS IF ANY OF THE FOLLOWING APPLIES:

1. A DENTAL SERVICE CORPORATION FILES A BASE RATE CHANGE AND THE ADMINISTRATIVE EXPENSE LOADING COMPONENT, INCLUDING TAXES AND ASSESSMENTS, INCREASED BY MORE THAN THE MOST RECENT CALENDAR YEAR'S PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR DENTAL SERVICES FOR ALL URBAN CONSUMERS, UNITED STATES CITY AVERAGE.

2. A DENTAL SERVICE CORPORATION'S REPORTED CONTRIBUTION TO SURPLUS EXCEEDS 1.9 PERCENT.

3. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A LARGE GROUP DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY-FIVE PERCENT.

4. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A SMALL GROUP DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT.

H. THE DENTAL SERVICE CORPORATION SHALL NOTIFY ALL SUBSCRIBERS UNDER THE SUBSCRIPTION CONTRACT IF THE DEPARTMENT PRESUMPTIVELY DENIES THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS.

I. A DENTAL SERVICE CORPORATION MAY NOT IMPLEMENT DENIED RATES UNLESS THE DEPARTMENT OR A COURT OF COMPETENT JURISDICTION REVERSES THE DENIAL.

J. A DENTAL SERVICE CORPORATION MAY REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

~~B.~~ K. This section does not restrict the ability of a dental service corporation to establish dental benefits for services offered by plans that are administered but not insured by the dental service corporation.

~~C.~~ L. For the purposes of this section: ~~,~~

1. "Covered service" means a service for which any reimbursement is available under a subscription contract without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, exclusion or other limitation.

2. "LARGE GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

3. "MEDICAL LOSS RATIO" MEANS THE PERCENTAGE OF ALL PREMIUMS THAT ARE COLLECTED BY A DENTAL SERVICE CORPORATION EACH YEAR AND THAT ARE SPENT ON DENTAL SERVICES AND ACTIVITIES THAT IMPROVE THE QUALITY OF DENTAL CARE, EXCLUDING FEDERAL AND STATE TAXES, LICENSING OR REGULATORY FEES, RISK ADJUSTMENT FEES, RISK CORRIDORS AND REINSURANCE COSTS.

4. "SMALL GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

Sec. 2. Section 20-1057.12, Arizona Revised Statutes, is amended to read:

20-1057.12. Contracts; dentists; covered services; medical loss ratio report; rebate; rates and rating factors; definitions

A. A contract~~,~~ entered into or renewed on ~~or after January 1, 2011,~~ between a health care services organization and a dentist who is licensed to practice in this state shall not require the dentist to provide ~~services~~ A SERVICE to an individual covered under an evidence of coverage based on a fee set by the health care services organization unless the ~~services~~ SERVICE for which the fee applies is a covered service under the individual's evidence of coverage.

B. BOTH OF THE FOLLOWING APPLY TO A HEALTH CARE SERVICES ORGANIZATION THAT OFFERS, ISSUES OR RENEWS AN EVIDENCE OF COVERAGE FOR DENTAL SERVICES:

1. ON OR BEFORE MARCH 31 OF EACH YEAR, THE HEALTH CARE SERVICES ORGANIZATION SHALL FILE WITH THE DEPARTMENT A MEDICAL LOSS RATIO REPORT THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE. THE MEDICAL LOSS RATIO REPORTING YEAR IS THE CALENDAR YEAR DURING WHICH DENTAL COVERAGE IS PROVIDED BY THE EVIDENCE OF COVERAGE. ALL TERMS USED IN THE MEDICAL LOSS RATIO REPORT SHALL HAVE THE SAME MEANINGS PRESCRIBED IN THE PUBLIC HEALTH SERVICE ACT (45 CODE OF FEDERAL REGULATIONS PART 158). THE MEDICAL LOSS RATIO REPORT SHALL CONTAIN THE FOLLOWING INFORMATION:

(a) THE COMPANY NAME.

(b) THE GROUP AFFILIATION.

(c) THE FEDERAL EMPLOYMENT IDENTIFICATION NUMBER.

(d) THE BEST CONTACT TELEPHONE NUMBER IN THE DAY TIME.
(e) THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS GROUP CODE.
(f) THE DOING BUSINESS AS NAME.
(g) THE ISSUER IDENTIFICATION NUMBER.
(h) BUSINESS, IN WHAT STATE.
(i) THE DOMICILIARY STATE.
(j) THE ADDRESS.
(k) THE FEDERAL TAX EXEMPT NUMBER.
(l) THE MARKETPLACE.
(m) THE MERGE MARKETS.
(n) THE NONPROFIT NUMBER.
(o) THE MEDICAL LOSS RATIO REPORTING YEAR.

2. IF DATA VERIFICATION OF A MEDICAL LOSS RATIO REPORT IS DEEMED NECESSARY, THE DEPARTMENT SHALL NOTIFY THE HEALTH CARE SERVICES ORGANIZATION AT LEAST THIRTY DAYS BEFORE BEGINNING ANY FINANCIAL EXAMINATION. THE HEALTH CARE SERVICES ORGANIZATION SHALL SUBMIT ALL REQUESTED DATA TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE NOTICE. ON A FINDING OF GOOD CAUSE, THE DEPARTMENT MAY EXTEND THE TIME FOR A HEALTH CARE SERVICES ORGANIZATION TO COMPLY WITH THIS PARAGRAPH.

C. THE DEPARTMENT SHALL MAKE AVAILABLE TO THE PUBLIC THE MEDICAL LOSS RATIO REPORT AND ALL DATA PROVIDED BY A HEALTH CARE SERVICES ORGANIZATION PURSUANT TO SUBSECTION B OF THIS SECTION.

D. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A HEALTH CARE SERVICES ORGANIZATION THAT PROVIDES SERVICES UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 4 OR THIS STATE'S HEALTH AND ACCIDENT INSURANCE PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 4.

E. A HEALTH CARE SERVICES ORGANIZATION OWES A REBATE TO ENROLLEES ON A PRO RATA BASIS BY AUGUST 1 FOLLOWING THE CALENDAR YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS FILED IF THE MEDICAL LOSS RATIO:

1. FOR A LARGE GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY-FIVE PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY-FIVE PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

2. FOR A SMALL GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

F. A HEALTH CARE SERVICES ORGANIZATION SHALL FILE GROUP PRODUCT BASE RATES AND ANY CHANGES TO THE GROUP RATING FACTORS THAT ARE TO BECOME EFFECTIVE JANUARY 1 OF EACH CALENDAR YEAR ON OR BEFORE JULY 1 OF THE PRECEDING YEAR. IF THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS ARE EXCESSIVE, INADEQUATE OR UNREASONABLE IN RELATION TO THE BENEFITS CHARGED OR ARE DISCRIMINATORY OR NOT ACTUARILY SOUND, THE DEPARTMENT SHALL DENY THE GROUP PRODUCT BASE RATES OR GROUP RATING FACTORS.

G. THE DEPARTMENT SHALL PRESUMPTIVELY DENY THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS IF ANY OF THE FOLLOWING APPLIES:

1. A HEALTH CARE SERVICES ORGANIZATION FILES A BASE RATE CHANGE AND THE ADMINISTRATIVE EXPENSE LOADING COMPONENT, INCLUDING TAXES AND ASSESSMENTS, INCREASED BY MORE THAN THE MOST RECENT CALENDAR YEAR'S PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR DENTAL SERVICES FOR ALL URBAN CONSUMERS, UNITED STATES CITY AVERAGE.

2. A HEALTH CARE SERVICES ORGANIZATION'S REPORTED CONTRIBUTION TO SURPLUS EXCEEDS 1.9 PERCENT.

3. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A LARGE GROUP HEALTH CARE SERVICES ORGANIZATION IS LESS THAN EIGHTY-FIVE PERCENT.

4. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A SMALL GROUP DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT.

H. THE HEALTH CARE SERVICES ORGANIZATION SHALL NOTIFY ALL ENROLLEES UNDER THE EVIDENCE OF COVERAGE IF THE DEPARTMENT PRESUMPTIVELY DENIES THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS.

I. A HEALTH CARE SERVICES ORGANIZATION MAY NOT IMPLEMENT DENIED RATES UNLESS THE DEPARTMENT OR A COURT OF COMPETENT JURISDICTION REVERSES THE DENIAL.

J. A HEALTH CARE SERVICES ORGANIZATION MAY REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

~~B.~~ K. This section does not restrict the ability of a health care services organization to establish dental benefits for services offered by plans that are administered but not insured by the health care services organization.

~~C.~~ L. For the purposes of this section: ~~,~~

1. "Covered service" means a service for which any reimbursement is available under an evidence of coverage without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, exclusion or other limitation.

2. "LARGE GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

3. "MEDICAL LOSS RATIO" MEANS THE PERCENTAGE OF ALL PREMIUMS THAT ARE COLLECTED BY A DENTAL SERVICE CORPORATION EACH YEAR AND THAT ARE SPENT ON DENTAL SERVICES AND ACTIVITIES THAT IMPROVE THE QUALITY OF DENTAL CARE, EXCLUDING FEDERAL AND STATE TAXES, LICENSING OR REGULATORY FEES, RISK ADJUSTMENT FEES, RISK CORRIDORS AND REINSURANCE COSTS.

4. "SMALL GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

Sec. 3. Section 20-1342.06, Arizona Revised Statutes, is amended to read:

20-1342.06. Contracts; dentists; covered services; medical loss ratio report; rebate; rates and rating factors; definitions

A. A contract~~,~~ entered into or renewed ~~on or after January 1, 2011,~~ between a disability insurer and a dentist who is licensed to practice in this state shall not require the dentist to provide ~~services~~ A SERVICE to an individual covered under a disability insurance policy based on a fee set by the disability insurer unless the ~~services~~ SERVICE for which the fee applies is a covered service under the individual's disability insurance policy.

B. BOTH OF THE FOLLOWING APPLY TO A DISABILITY INSURER THAT OFFERS, ISSUES OR RENEWS A DISABILITY INSURANCE POLICY COVERING DENTAL SERVICES:

1. ON OR BEFORE MARCH 31 OF EACH YEAR, THE DISABILITY INSURER SHALL FILE WITH THE DEPARTMENT A MEDICAL LOSS RATIO REPORT THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE. THE MEDICAL LOSS RATIO REPORTING YEAR IS THE CALENDAR YEAR DURING WHICH DENTAL COVERAGE IS PROVIDED BY THE CONTRACT. ALL TERMS USED IN THE MEDICAL LOSS RATIO REPORT SHALL HAVE THE SAME MEANINGS PRESCRIBED IN THE PUBLIC HEALTH SERVICE ACT (45 CODE OF FEDERAL REGULATIONS PART 158). THE MEDICAL LOSS RATIO REPORT SHALL CONTAIN THE FOLLOWING INFORMATION:

(a) THE COMPANY NAME.
(b) THE GROUP AFFILIATION.
(c) THE FEDERAL EMPLOYMENT IDENTIFICATION NUMBER.
(d) THE BEST CONTACT TELEPHONE NUMBER IN THE DAY TIME.
(e) THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS GROUP CODE.
(f) THE DOING BUSINESS AS NAME.
(g) THE ISSUER IDENTIFICATION NUMBER.
(h) BUSINESS, IN WHAT STATE.
(i) THE DOMICILIARY STATE.
(j) THE ADDRESS.
(k) THE FEDERAL TAX EXEMPT NUMBER.
(l) THE MARKETPLACE.
(m) THE MERGE MARKETS.
(n) THE NONPROFIT NUMBER.
(o) THE MEDICAL LOSS RATIO REPORTING YEAR.

2. IF DATA VERIFICATION OF A MEDICAL LOSS RATIO REPORT IS DEEMED NECESSARY, THE DEPARTMENT SHALL NOTIFY THE DISABILITY INSURER AT LEAST THIRTY DAYS BEFORE BEGINNING ANY FINANCIAL EXAMINATION. THE DISABILITY INSURER SHALL SUBMIT ALL REQUESTED DATA TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE NOTICE. ON A FINDING OF GOOD CAUSE, THE DEPARTMENT MAY EXTEND THE TIME FOR A DISABILITY INSURER TO COMPLY WITH THIS PARAGRAPH.

C. THE DEPARTMENT SHALL MAKE AVAILABLE TO THE PUBLIC THE MEDICAL LOSS RATIO REPORT AND ALL DATA PROVIDED BY A DISABILITY INSURER PURSUANT TO SUBSECTION B OF THIS SECTION.

D. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A DISABILITY INSURER THAT PROVIDES SERVICES UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 4 OR THIS STATE'S HEALTH AND ACCIDENT INSURANCE PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 4.

E. A DISABILITY INSURER OWES A REBATE TO INSUREDS ON A PRO RATA BASIS BY AUGUST 1 FOLLOWING THE CALENDAR YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS FILED IF THE MEDICAL LOSS RATIO:

1. FOR A LARGE GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY-FIVE PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY-FIVE PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

2. FOR A SMALL GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

F. A DISABILITY INSURER SHALL FILE GROUP PRODUCT BASE RATES AND ANY CHANGES TO THE GROUP RATING FACTORS THAT ARE TO BECOME EFFECTIVE JANUARY 1 OF EACH CALENDAR YEAR ON OR BEFORE JULY 1 OF THE PRECEDING YEAR. IF THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS ARE EXCESSIVE, INADEQUATE OR UNREASONABLE IN RELATION TO THE BENEFITS CHARGED OR ARE DISCRIMINATORY OR NOT ACTUARILY SOUND, THE DEPARTMENT SHALL DENY THE GROUP PRODUCT BASE RATES OR GROUP RATING FACTORS.

G. THE DEPARTMENT SHALL PRESUMPTIVELY DENY THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS IF ANY OF THE FOLLOWING APPLIES:

1. A DISABILITY INSURER FILES A BASE RATE CHANGE AND THE ADMINISTRATIVE EXPENSE LOADING COMPONENT, INCLUDING TAXES AND ASSESSMENTS, INCREASED BY MORE THAN THE MOST RECENT CALENDAR YEAR'S PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR DENTAL SERVICES FOR ALL URBAN CONSUMERS, UNITED STATES CITY AVERAGE.

2. A DISABILITY INSURER'S REPORTED CONTRIBUTION TO SURPLUS EXCEEDS 1.9 PERCENT.

3. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A LARGE GROUP DISABILITY INSURER IS LESS THAN EIGHTY-FIVE PERCENT.

4. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A SMALL GROUP DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT.

H. THE DISABILITY INSURER SHALL NOTIFY ALL INSUREDS UNDER THE DISABILITY INSURANCE POLICY IF THE DEPARTMENT PRESUMPTIVELY DENIES THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS.

I. A DISABILITY INSURER MAY NOT IMPLEMENT DENIED RATES UNLESS THE DEPARTMENT OR A COURT OF COMPETENT JURISDICTION REVERSES THE DENIAL.

J. A DISABILITY INSURER MAY REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

~~B.~~ K. This section does not restrict the ability of a disability insurer to establish dental benefits for services offered by plans that are administered but not insured by the disability insurer.

~~C.~~ L. For the purposes of this section: ~~,~~

1. "Covered service" means a service for which any reimbursement is available under a disability insurance policy without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, exclusion or other limitation.

2. "LARGE GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

3. "MEDICAL LOSS RATIO" MEANS THE PERCENTAGE OF ALL PREMIUMS THAT ARE COLLECTED BY A DENTAL SERVICE CORPORATION EACH YEAR AND THAT ARE SPENT ON DENTAL SERVICES AND ACTIVITIES THAT IMPROVE THE QUALITY OF DENTAL CARE, EXCLUDING FEDERAL AND STATE TAXES, LICENSING OR REGULATORY FEES, RISK ADJUSTMENT FEES, RISK CORRIDORS AND REINSURANCE COSTS.

4. "SMALL GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

Sec. 4. Section 20-1402.04, Arizona Revised Statutes, is amended to read:

20-1402.04. Contracts; dentists; covered services; medical loss ratio report; rebate; rates and rating factors; definitions

A. A contract~~,~~ entered into or renewed ~~on or after January 1, 2011,~~ between a group disability insurer and a dentist who is licensed to practice in this state shall not require the dentist to provide ~~services~~ A SERVICE to an individual covered under a group disability policy based on a fee set by the group disability insurer unless the ~~services~~ SERVICE for which the fee applies is a covered service under the individual's group disability policy.

B. BOTH OF THE FOLLOWING APPLY TO A GROUP DISABILITY INSURER THAT OFFERS, ISSUES OR RENEWS A GROUP DISABILITY INSURANCE POLICY COVERING DENTAL SERVICES:

1. ON OR BEFORE MARCH 31 OF EACH YEAR, THE GROUP DISABILITY INSURER SHALL FILE WITH THE DEPARTMENT A MEDICAL LOSS RATIO REPORT THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE. THE MEDICAL LOSS RATIO REPORTING YEAR IS THE CALENDAR YEAR DURING WHICH DENTAL COVERAGE IS PROVIDED BY THE CONTRACT. ALL TERMS USED IN THE MEDICAL LOSS RATIO REPORT SHALL HAVE THE SAME MEANINGS PRESCRIBED IN THE PUBLIC HEALTH SERVICE ACT (45 CODE OF FEDERAL REGULATIONS PART 158). THE MEDICAL LOSS RATIO REPORT SHALL CONTAIN THE FOLLOWING INFORMATION:

(a) THE COMPANY NAME.

(b) THE GROUP AFFILIATION.

(c) THE FEDERAL EMPLOYMENT IDENTIFICATION NUMBER.

(d) THE BEST CONTACT TELEPHONE NUMBER IN THE DAY TIME.

(e) THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS GROUP CODE.
(f) THE DOING BUSINESS AS NAME.
(g) THE ISSUER IDENTIFICATION NUMBER.
(h) BUSINESS, IN WHAT STATE.
(i) THE DOMICILIARY STATE.
(j) THE ADDRESS.
(k) THE FEDERAL TAX EXEMPT NUMBER.
(l) THE MARKETPLACE.
(m) THE MERGE MARKETS.
(n) THE NONPROFIT NUMBER.
(o) THE MEDICAL LOSS RATIO REPORTING YEAR.

2. IF DATA VERIFICATION OF A MEDICAL LOSS RATIO REPORT IS DEEMED NECESSARY, THE DEPARTMENT SHALL NOTIFY THE GROUP DISABILITY INSURER AT LEAST THIRTY DAYS BEFORE BEGINNING ANY FINANCIAL EXAMINATION. THE DENTAL SERVICE CORPORATION SHALL SUBMIT ALL REQUESTED DATA TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE NOTICE. ON A FINDING OF GOOD CAUSE, THE DEPARTMENT MAY EXTEND THE TIME FOR A GROUP DISABILITY INSURER TO COMPLY WITH THIS PARAGRAPH.

C. THE DEPARTMENT SHALL MAKE AVAILABLE TO THE PUBLIC THE MEDICAL LOSS RATIO REPORT AND ALL DATA PROVIDED BY A GROUP DISABILITY INSURER PURSUANT TO SUBSECTION B OF THIS SECTION.

D. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A DENTAL SERVICE CORPORATION THAT PROVIDES SERVICES UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 4 OR THIS STATE'S HEALTH AND ACCIDENT INSURANCE PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 4.

E. A GROUP DISABILITY INSURER OWES A REBATE TO INSUREDS ON A PRO RATA BASIS BY AUGUST 1 FOLLOWING THE CALENDAR YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS FILED IF THE MEDICAL LOSS RATIO:

1. FOR A LARGE GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY-FIVE PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY-FIVE PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

2. FOR A SMALL GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

F. A GROUP DISABILITY INSURER SHALL FILE GROUP PRODUCT BASE RATES AND ANY CHANGES TO THE GROUP RATING FACTORS THAT ARE TO BECOME EFFECTIVE JANUARY 1 OF EACH CALENDAR YEAR ON OR BEFORE JULY 1 OF THE PRECEDING YEAR. IF THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS ARE EXCESSIVE, INADEQUATE OR UNREASONABLE IN RELATION TO THE BENEFITS CHARGED OR ARE DISCRIMINATORY OR NOT ACTUARILY SOUND, THE DEPARTMENT SHALL DENY THE GROUP PRODUCT BASE RATES OR GROUP RATING FACTORS.

G. THE DEPARTMENT SHALL PRESUMPTIVELY DENY THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS IF ANY OF THE FOLLOWING APPLIES:

1. A GROUP DISABILITY INSURER FILES A BASE RATE CHANGE AND THE ADMINISTRATIVE EXPENSE LOADING COMPONENT, INCLUDING TAXES AND ASSESSMENTS,

INCREASED BY MORE THAN THE MOST RECENT CALENDAR YEAR'S PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR DENTAL SERVICES FOR ALL URBAN CONSUMERS, UNITED STATES CITY AVERAGE.

2. A GROUP DISABILITY INSURER REPORTED CONTRIBUTION TO SURPLUS EXCEEDS 1.9 PERCENT.

3. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A LARGE GROUP DISABILITY INSURER IS LESS THAN EIGHTY-FIVE PERCENT.

4. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A SMALL GROUP DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT.

H. THE GROUP DISABILITY INSURER SHALL NOTIFY ALL INSUREDS UNDER THE GROUP DISABILITY POLICY IF THE DEPARTMENT PRESUMPTIVELY DENIES THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS.

I. A GROUP DISABILITY INSURER MAY NOT IMPLEMENT DENIED RATES UNLESS THE DEPARTMENT OR A COURT OF COMPETENT JURISDICTION REVERSES THE DENIAL.

J. A GROUP DISABILITY INSURER MAY REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

~~B.~~ K. This section does not restrict the ability of a group disability insurer to establish dental benefits for services offered by plans that are administered but not insured by the group disability insurer.

~~C.~~ L. For the purposes of this section: ~~,~~

1. "Covered service" means a service for which any reimbursement is available under a group disability policy without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, exclusion or other limitation.

2. "LARGE GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

3. "MEDICAL LOSS RATIO" MEANS THE PERCENTAGE OF ALL PREMIUMS THAT ARE COLLECTED BY A DENTAL SERVICE CORPORATION EACH YEAR AND THAT ARE SPENT ON DENTAL SERVICES AND ACTIVITIES THAT IMPROVE THE QUALITY OF DENTAL CARE, EXCLUDING FEDERAL AND STATE TAXES, LICENSING OR REGULATORY FEES, RISK ADJUSTMENT FEES, RISK CORRIDORS AND REINSURANCE COSTS.

4. "SMALL GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

Sec. 5. Section 20-1404.04, Arizona Revised Statutes, is amended to read:

20-1404.04. Contracts; dentists; covered services; medical loss ratio report; rebate; rates and rating factors; definitions

A. A contract~~,~~ entered into or renewed ~~on or after January 1, 2011,~~ between a blanket disability insurer and a dentist who is licensed to practice in this state shall not require the dentist to provide ~~services~~ A SERVICE to an individual covered under a blanket disability policy based on a fee set by the blanket disability insurer unless the

~~services~~ SERVICE for which the fee applies is a covered service under the individual's blanket disability policy.

B. BOTH OF THE FOLLOWING APPLY TO A BLANKET DISABILITY INSURER THAT OFFERS, ISSUES OR RENEWS A BLANKET DISABILITY POLICY COVERING DENTAL SERVICES:

1. ON OR BEFORE MARCH 31 OF EACH YEAR, THE BLANKET DISABILITY INSURER SHALL FILE WITH THE DEPARTMENT A MEDICAL LOSS RATIO REPORT THAT IS ORGANIZED BY MARKET AND PRODUCT TYPE. THE MEDICAL LOSS RATIO REPORTING YEAR IS THE CALENDAR YEAR DURING WHICH DENTAL COVERAGE IS PROVIDED BY THE CONTRACT. ALL TERMS USED IN THE MEDICAL LOSS RATIO REPORT SHALL HAVE THE SAME MEANINGS PRESCRIBED IN THE PUBLIC HEALTH SERVICE ACT (45 CODE OF FEDERAL REGULATIONS PART 158). THE MEDICAL LOSS RATIO REPORT SHALL CONTAIN THE FOLLOWING INFORMATION:

(a) THE COMPANY NAME.

(b) THE GROUP AFFILIATION.

(c) THE FEDERAL EMPLOYMENT IDENTIFICATION NUMBER.

(d) THE BEST CONTACT TELEPHONE NUMBER IN THE DAY TIME.

(e) THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS GROUP CODE.

(f) THE DOING BUSINESS AS NAME.

(g) THE ISSUER IDENTIFICATION NUMBER.

(h) BUSINESS, IN WHAT STATE.

(i) THE DOMICILIARY STATE.

(j) THE ADDRESS.

(k) THE FEDERAL TAX EXEMPT NUMBER.

(l) THE MARKETPLACE.

(m) THE MERGE MARKETS.

(n) THE NONPROFIT NUMBER.

(o) THE MEDICAL LOSS RATIO REPORTING YEAR.

2. IF DATA VERIFICATION OF A MEDICAL LOSS RATIO REPORT IS DEEMED NECESSARY, THE DEPARTMENT SHALL NOTIFY THE BLANKET DISABILITY INSURER AT LEAST THIRTY DAYS BEFORE BEGINNING ANY FINANCIAL EXAMINATION. THE BLANKET DISABILITY INSURER SHALL SUBMIT ALL REQUESTED DATA TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE NOTICE. ON A FINDING OF GOOD CAUSE, THE DEPARTMENT MAY EXTEND THE TIME FOR A BLANKET DISABILITY INSURER TO COMPLY WITH THIS PARAGRAPH.

C. THE DEPARTMENT SHALL MAKE AVAILABLE TO THE PUBLIC THE MEDICAL LOSS RATIO REPORT AND ALL DATA PROVIDED BY A BLANKET DISABILITY INSURER PURSUANT TO SUBSECTION B OF THIS SECTION.

D. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A BLANKET DISABILITY INSURER THAT PROVIDES SERVICES UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 4 OR THIS STATE'S HEALTH AND ACCIDENT INSURANCE PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 4.

E. A BLANKET DISABILITY INSURER OWES A REBATE TO INSUREDS ON A PRO RATA BASIS BY AUGUST 1 FOLLOWING THE CALENDAR YEAR FOR WHICH THE MEDICAL LOSS RATIO WAS FILED IF THE MEDICAL LOSS RATIO:

1. FOR A LARGE GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY-FIVE PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY-FIVE PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

2. FOR A SMALL GROUP MARKET DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT. THE REBATE CALCULATION IS THE PERCENTAGE AMOUNT UNDER EIGHTY PERCENT MULTIPLIED BY THE TOTAL PREMIUM REVENUE.

F. A BLANKET DISABILITY INSURER SHALL FILE GROUP PRODUCT BASE RATES AND ANY CHANGES TO THE GROUP RATING FACTORS THAT ARE TO BECOME EFFECTIVE JANUARY 1 OF EACH CALENDAR YEAR ON OR BEFORE JULY 1 OF THE PRECEDING YEAR. IF THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS ARE EXCESSIVE, INADEQUATE OR UNREASONABLE IN RELATION TO THE BENEFITS CHARGED OR ARE DISCRIMINATORY OR NOT ACTUARILY SOUND, THE DEPARTMENT SHALL DENY THE GROUP PRODUCT BASE RATES OR GROUP RATING FACTORS.

G. THE DEPARTMENT SHALL PRESUMPTIVELY DENY THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS IF ANY OF THE FOLLOWING APPLIES:

1. A BLANKET DISABILITY INSURER FILES A BASE RATE CHANGE AND THE ADMINISTRATIVE EXPENSE LOADING COMPONENT, INCLUDING TAXES AND ASSESSMENTS, INCREASED BY MORE THAN THE MOST RECENT CALENDAR YEAR'S PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR DENTAL SERVICES FOR ALL URBAN CONSUMERS, UNITED STATES CITY AVERAGE.

2. A BLANKET DISABILITY INSURER'S REPORTED CONTRIBUTION TO SURPLUS EXCEEDS 1.9 PERCENT.

3. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A LARGE GROUP BLANKET DISABILITY POLICY IS LESS THAN EIGHTY-FIVE PERCENT.

4. THE AGGREGATE MEDICAL LOSS RATIO FOR ALL PLANS OFFERED BY A SMALL GROUP DENTAL SERVICE CORPORATION IS LESS THAN EIGHTY PERCENT.

H. THE BLANKET DISABILITY INSURER SHALL NOTIFY ALL INSUREDS UNDER THE BLANKET DISABILITY POLICY IF THE DEPARTMENT PRESUMPTIVELY DENIES THE GROUP PRODUCT BASE RATES OR THE GROUP RATING FACTORS.

I. A BLANKET DISABILITY INSURER MAY NOT IMPLEMENT DENIED RATES UNLESS THE DEPARTMENT OR A COURT OF COMPETENT JURISDICTION REVERSES THE DENIAL.

J. A BLANKET DISABILITY INSURER MAY REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

~~B.~~ K. This section does not restrict the ability of a blanket disability insurer to establish dental benefits for services offered by plans that are administered but not insured by the blanket disability insurer.

~~C.~~ L. For the purposes of this section: ~~,~~

1. "Covered service" means a service for which any reimbursement is available under a blanket disability policy without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period,

annual or lifetime maximum, frequency limitation, alternative benefit payment, exclusion or other limitation.

2. "LARGE GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.

3. "MEDICAL LOSS RATIO" MEANS THE PERCENTAGE OF ALL PREMIUMS THAT ARE COLLECTED BY A DENTAL SERVICE CORPORATION EACH YEAR AND THAT ARE SPENT ON DENTAL SERVICES AND ACTIVITIES THAT IMPROVE THE QUALITY OF DENTAL CARE, EXCLUDING FEDERAL AND STATE TAXES, LICENSING OR REGULATORY FEES, RISK ADJUSTMENT FEES, RISK CORRIDORS AND REINSURANCE COSTS.

4. "SMALL GROUP MARKET" HAS THE SAME MEANING PRESCRIBED IN 42 UNITED STATES CODE SECTION 18024.