HOUSE BILL NO. 273

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE RUFFRIDGE

Introduced: 1/23/26
Referred: Health and Social Services, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act relating to direct health care agreements; relating to dental health care insurance plans and dental loss ratios; and providing for an effective date."

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

*** Section 1.** AS 21.03.025(a) is amended to read:

(a) A health care provider or health care business and a patient or the representative of a patient may enter into a direct health care agreement. **The** [HEALTH CARE] services provided under a direct health care agreement are limited to **dental care services and** the type of health care services that a primary care provider may provide to a patient. A patient is not eligible to enter into a direct health care agreement under this section if the patient is eligible to receive assistance under AS 47.07 (Medical Assistance for Needy Persons) or AS 47.08 (Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions).

*** Sec. 2.** AS 21.03.025(c) is amended to read:

(c) A direct health care agreement must

(1) describe the **dental care services or** health care services that the health care provider or health care business makes available to the patient in exchange for payment of a periodic fee and each location at which the **dental care services or** health care services are available;

(2) specify

(A) the amount of the periodic fee a patient or the representative of a patient pays in exchange for the **dental care services or** health care services that the health care provider or health care business makes available to the patient;

(B) the period covered by the periodic fee under (A) of this paragraph; and

(C) additional fees that the health care provider or health care business may charge in addition to the periodic fee, including cancellation fees;

(3) identify and include contact information for a representative of the health care provider or health care business that is responsible for receiving and addressing

(A) a complaint made by a patient relating to the agreement; and

(B) a request made by a patient to amend the agreement, including a patient's request to change the name of the representative of the patient or the patient's mailing address, physical address, telephone number, electronic mail address, or other personal information;

(4) prominently state that the patient is not entitled to the protections under AS 21.07 (Patient Protections Under Health Care Insurance Policies and Prior Authorizations).

*** Sec. 3.** AS 21.03.025(m) is amended to read:

(m) A direct health care agreement and a health care provider or health care business providing **dental care services or** health care services under a direct health care agreement are subject to AS 21.36 (Trade Practices and Frauds) to the extent applicable and when not in conflict with the express provisions of this section.

*** Sec. 4.** AS 21.03.025(o) is amended to read:

(o) A health care provider or health care business may decline to enter into a direct health care agreement with a new patient if the health care provider or health care business

(1) is unable to provide to the patient the **dental care services or** health care services the patient requires; or

(2) does not have the capacity to accept new patients.

*** Sec. 5.** AS 21.03.025(p) is amended to read:

(p) A health care provider or health care business may terminate a direct health care agreement with an existing patient based on the patient's health status only if the health care provider is unable to provide to the patient the **dental care services or** health care services the patient requires or in accordance with this section.

*** Sec. 6.** AS 21.03.025(r)(1) is amended to read:

(1) "direct health care agreement" means a written agreement between a health care provider or health care business and a patient or the representative of a patient to provide **dental care services or** health care services in exchange for payment of a periodic fee;

*** Sec. 7.** AS 21.96 is amended by adding new sections to read:

Sec. 21.96.210. Dental loss ratio report. (a) An insurer that offers, issues for delivery, delivers, or renews in this state a specialized dental health care service plan shall annually file a dental loss ratio report with the director that is organized by market and product type, contains the same information required in the federal Centers for Medicare and Medicaid Services medical loss ratio annual reporting form for the 2013 medical loss ratio reporting year, and 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. The report must contain information for the most recent complete fiscal year during which the plan provided dental coverage.

(b) All terms used in the dental loss ratio report must have the same meaning as the terms used in 42 U.S.C. 300gg-18 and supporting federal regulations.

(c) If the director considers it necessary to verify the data of the insurer in the

dental loss ratio report, the director shall notify the insurer and allow the insurer 30 days to submit any requested information.

(d) By January 1 of the year after the director receives the dental loss ratio report, the director shall make the information, including the aggregate dental loss ratio and other data reported under this section, available to the public in a searchable format that allows members of the public to compare dental loss ratios among carriers by plan type by posting the information on the division's Internet website or providing the information to the administrator of an all-payer health claims database. If the director provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the director.

(e) The director shall file a report with the data collected under this section with the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available. The report must list plans identified as outliers under AS 21.96.215(b), and show changes from year to year in the status of insurers' plans relative to meeting the standard in AS 21.96.215(b).

(f) In this section, the percentage of premium dollars spent on patient care is calculated by dividing the numerator by the denominator, where

(1) 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 as defined by the commissioner in regulation not to exceed five percent of net premium revenue, and other incurred claims as defined in 45 C.F.R. 158.140(a); overhead and administrative costs, as defined by the commissioner in regulation, may not be included in the numerator; and

(2) the denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures as defined in 45 C.F.R. 158.162(c), and other payments required by federal law.

(g) In this section,

(1) "dental health care service plan" means a plan that provides coverage for dental health care services to enrollees in exchange for premiums; "dental health care service plan" does not include Medicaid or Children's Health Insurance

Program plans;

(2) "dental loss ratio" means the percentage of premium dollars spent on patient care, as calculated under (e) of this section;

(3) "insurer" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

Sec. 21.96.215. Outliers and remediation. (a) The director shall aggregate the dental loss ratios for each insurer by year using the data provided under AS 21.96.210 for each market segment in which the insurer operates. The director shall calculate an average dental loss ratio for each market segment using aggregate data for a three-year period, including data for the most recent dental loss ratio reporting year and the data for the previous two dental loss ratio reporting years. If 50 percent or more of the total earned premium during a reporting year is attributable to policies newly issued in that reporting year, the director may exclude the experience of these policies in calculating an insurer's aggregate dental loss ratio for that reporting year. The director shall add the excluded experience to the experience reported in the following reporting year.

(b) The director shall identify as outliers dental health care service plans that fall outside one standard deviation of the average dental loss ratio for that market segment. An insurer is not an outlier under this subsection if the dental loss ratio in a market segment is within three percentage points of the average dental loss ratio. A higher threshold may be set by the director as determined reasonable by the director.

(c) The director shall investigate an insurer that reports a dental loss ratio lower than one standard deviation from the mathematical average and may take remediation or enforcement actions against the insurer, including ordering the insurer to rebate, consistent with federal law, premiums paid above amounts that would have caused the insurer to have achieved the mathematical average of the data submitted in a given year for a given market segment.

(d) If the dental loss ratio for an insurer in a market segment does not increase and remains an outlier under (b) of this section after two consecutive years, the director shall, except under reasonable circumstances as determined by the director, subject the insurer to a minimum dental loss ratio percentage by market segment. The

director shall adopt regulations establishing the dental loss ratio percentage based on, at minimum, the average of existing insurer loss ratios by market segment in the state effective not earlier than 42 months after the insurer is determined to be an outlier under this section.

(e) An insurer subject to remediation under (c) or (d) of this section shall provide a rebate owed to a policyholder as required by the director. The director may establish alternatives to providing rebates, including premium reductions in the following benefit year.

(f) The director may adopt regulations to create a process to identify insurers that increase rates more than the percentage increase of the latest dental services Consumer Price Index for all urban consumers for urban Alaska as reported by the United States Bureau of Labor Statistics.

(g) In this section,

(1) "dental health care service plan" has the meaning given in AS 21.96.210;

(2) "dental loss ratio" has the meaning given in AS 21.96.210;

(3) "insurer" has the meaning given in AS 21.96.210.

*** Sec. 8.** This Act takes effect January 1, 2027.