

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 729

BY HEALTH AND WELFARE COMMITTEE

AN ACT

1 RELATING TO THE IDAHO DENTAL PLAN TRANSPARENCY ACT; AMENDING TITLE 41, IDAHO
2 CODE, BY THE ADDITION OF A NEW CHAPTER 67, TITLE 41, IDAHO CODE, TO PRO-
3 VIDE A SHORT TITLE, TO DEFINE TERMS, AND TO PROVIDE FOR TRANSPARENCY
4 OF DENTAL HEALTH CARE SERVICE PLAN PATIENT PREMIUMS; AND DECLARING AN
5 EMERGENCY AND PROVIDING AN EFFECTIVE DATE.
6

7 Be It Enacted by the Legislature of the State of Idaho:

8 SECTION 1. That Title 41, Idaho Code, be, and the same is hereby amended
9 by the addition thereto of a NEW CHAPTER, to be known and designated as Chap-
10 ter 67, Title 41, Idaho Code, and to read as follows:

11 CHAPTER 67

12 IDAHO DENTAL PLAN TRANSPARENCY ACT

13 41-6701. SHORT TITLE. This act shall be known and may be cited as the
14 "Idaho Dental Plan Transparency Act."

15 41-6702. DEFINITIONS. For the purposes of this chapter:

16 (1) "Dental health care service plan" means any plan that provides
17 coverage for dental health care services to plan enrollees in exchange for
18 premiums. Dental health care service plan does not include plans under med-
19 icaid, the children's health insurance program (CHIP), short-term health
20 plans, accident-only plans, emergency benefits embedded in a medical plan,
21 or direct primary care agreements.

22 (2) "Dental loss ratio" or "DLR" means a ratio used to determine the
23 percentage of all premium funds collected by an insurer or dental health care
24 service plan each year that is spent on actual enrollee patient care and may
25 include oral health-related community health benefit spending but shall not
26 include overhead or other costs.

27 (3) "Department" means the Idaho department of insurance.

28 (4) "Earned premium" means all moneys paid by an enrollee or subscriber
29 as a condition of receiving coverage from the issuer, including any fees or
30 other contributions associated with a dental health care service plan.

31 (5) "Incurred claims" means claims relating to services that were pro-
32 vided in a reporting year, which includes claims that were paid in such re-
33 porting year plus unpaid claim reserves for claims paid after such reporting
34 year.

35 (6) "Unpaid claim reserves" means reserves and liabilities established
36 to account for claims that were incurred during a DLR reporting year but were
37 not paid within three (3) months of the end of such DLR reporting year.

38 41-6703. TRANSPARENCY OF DENTAL HEALTH CARE SERVICE PLAN PATIENT PRE-
39 MIUMS. (1) A dental health care service plan that issues, sells, renews, or

1 offers a specialized health care service plan contract covering dental ser-
2 vices shall file annually a DLR report with the department that covers all
3 dental health care service plans offered. Beginning in 2027, such report
4 shall be submitted annually on or before July 31. The department shall an-
5 nually review and publish reports submitted pursuant to this subsection by
6 January 1 each year.

7 (2) A DLR reporting year shall be for a calendar year when dental cover-
8 age was provided by a dental health care service plan.

9 (3) A DLR report shall include a brief overview of what was included
10 in the calculation for the numerator and denominator of the DLR along with
11 the final ratio figure. If a dental health care service plan includes oral
12 health-related community health benefit spending in its DLR computation, it
13 shall report the value of any such amount being included.

14 (4) If the department requires additional data verification of a dental
15 health care service plan's representations pursuant to a DLR report submit-
16 ted pursuant to this section, the department shall provide the dental health
17 care service plan with notification of such requirement within thirty (30)
18 days after the due date of such DLR report. The dental health care service
19 plan shall have thirty (30) days after receipt of such notice, or such ad-
20 ditional time as the department may grant at its discretion, to submit a re-
21 sponse.

22 (5) A dental health care service plan shall electronically submit the
23 information described in this section in a format and according to instruc-
24 tions prescribed by the department.

25 (6) By January 1 of the year after the department has received a DLR re-
26 port pursuant to this section, the department shall make such information,
27 including the aggregate DLR and other data reported, available to the public
28 in a searchable format on a website that is available to the public and allows
29 for the comparison of DLRs among dental health care service plans.

30 (7) DLRs shall be calculated by dividing the numerator by the denomina-
31 tor as follows:

32 (a) The numerator shall be the amount spent on services for plan en-
33 rollees.

34 (i) The amount spent on services for plan enrollees includes:

35 1. The amount expended for clinical dental services that are
36 services within the code on dental procedures and nomencla-
37 ture provided to enrollees that shall include payments under
38 capitation contracts with dental providers whose services
39 are covered by the contract for dental clinical services or
40 supplies covered by the contract;

41 2. Unpaid claim reserves;

42 3. Any claim payment recovered by insurers from providers or
43 enrollees using utilization management efforts that shall
44 be deducted from incurred claim amounts;

45 4. The amount paid to providers on activities that improve
46 oral health through clinical services for plan enrollees,
47 limited to activities directed toward individual enrollees;
48 and

49 5. Oral health improvement activities, such as patient-fac-
50 ing programs that improve oral health outcomes through com-

1 munity outreach, education, screening, grants, or workforce
2 development investment.

3 (ii) Any overpayment that has already been received from
4 providers should not be reported as a paid claim. Overpayment re-
5 coveries received from providers shall be deducted from incurred
6 claim amounts.

7 (iii) The calculation of the numerator shall not include:

8 1. Any administrative costs, including but not limited to
9 infrastructure, personnel costs, or broker payments;

10 2. Amounts paid to third-party vendors for secondary net-
11 work savings;

12 3. Amounts spent internally or paid to third-party vendors
13 for network development, administrative fees, claims pro-
14 cessing, utilization management, or expenditures designed
15 primarily to control or contain costs;

16 4. Amounts paid to providers for professional or admin-
17 istrative services that do not represent compensation or
18 reimbursement for covered services provided to an enrollee,
19 including but not limited to dental record copying costs,
20 attorney's fees, subrogation vendor fees, compensation to
21 paraprofessionals, janitors, quality assurance analysts,
22 administrative supervisors, secretaries to dental person-
23 nel, and dental record clerks;

24 5. Amounts for services or expenditures paid for with grant
25 money or other funding separate from premium revenue;

26 6. Any funds withheld from providers for any reason;

27 7. Overpayments recovered from providers;

28 8. Any cost-sharing amount paid by the plan enrollee;

29 9. Adjustments recouped pursuant to coordination of benefit
30 policies;

31 10. Payments recovered through fraud reduction efforts; or

32 11. Share of expenses that are for lines of business or prod-
33 ucts other than those being reported, including but not lim-
34 ited to those that are for or benefit self-funded plans is-
35 sued by the same carrier.

36 (b) The denominator shall be the total amount of a dental health care
37 service plan's earned premium revenues, excluding federal and state
38 taxes and licensing and regulatory fees paid after accounting for any
39 payments pursuant to federal law.

40 SECTION 2. An emergency existing therefor, which emergency is hereby
41 declared to exist, this act shall be in full force and effect on and after
42 July 1, 2026.