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COMMISSIONER OF SECURITIES AND INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

NOTICE OF ADOPTION

MAR NOTICE NO. 2026-119.2

Summary

Adoption of NEW RULES 1 and 2 implementing the Montana Dental Insurance Transparency and Accountability Act

Previous Notice(s) and Hearing Information

On June 5, 2026, the Office of the State Auditor, Commissioner of Securities and Insurance (CSI) published MAR Notice No. 2026-119.1 pertaining to the public hearing on the proposed adoption of the above-stated rules in the 2026 Montana Administrative Register, Issue Number 11. CSI held a public hearing on the proposed rulemaking on June 25, 2026.

Final Rulemaking Action – Effective September 26, 2026

ADOPT WITH CHANGES

The agency has adopted the following rules with changes from the original proposal, stricken matter interlined, new matter underlined:

NEW RULE 1 (6.6.9201) CALCULATION OF THE DENTAL LOSS RATIO

(1) For purposes of calculating the dental loss ratio specified in 33-22-2202, MCA, the following definitions apply:

(a) "Clinical dental services provided to enrollees" means:

(i) diagnostic, preventive, or corrective procedures provided by any oral health care provider, including but not limited to licensed dentists, dental therapists, licensed dental hygienists, dental assistants, and

licensed denturists in the practice of their profession, including treatment of the teeth and associated structures of the oral cavity and treatment for disease, injury, or impairment that may affect the oral or general health of the enrollee;

(ii) expenditures for dental claims incurred (before reinsurance), including claims incurred but not reported (IBNR) for enrollees, and payments under capitation contracts with dental providers whose services are covered by the contract.

(b) "Clinical dental services provided to enrollees" do not include:

(i) activities that improve dental care quality. These activities are a separate component of dental loss ratio described in (1)(c);

(ii) overhead and administrative cost expenditures; or

(iii) activities that are nonprofit community benefit expenditures.

(c) "Activities that improve dental care quality" means an activity that meets the following requirements:

(i) The activity is intended to improve oral and overall health and advance oral health quality, including increasing the likelihood of desired outcomes compared to a baseline; reducing dental disparities among specified populations; and improving patient safety, reducing medical error, or lowering infection in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(ii) The activity is directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provides oral health improvements to the population beyond those enrolled in coverage, as long as no credit is taken for additional costs incurred due to the non-enrollees.

(iii) The activity is grounded in the implementation, development, or improvement of evidence-based medicine, widely accepted best clinical practices, or criteria issued by recognized professional dental associations, accreditation bodies, government agencies, or other nationally recognized dental care quality organizations.

(d) "Activities that improve dental care quality" do not include:

(i) activities relating to lines of business or products other than dental, including the pro rata share of expenditures relating to both dental and non-dental business;

(ii) activities paid for with grant money or other funding separate from premium revenue;

(iii) activities that can be billed or allocated by a provider for care delivery and are reimbursed as clinical dental services;

(iv) taxes and assessments;

(v) fines and penalties of regulatory authorities, and fees for examinations by any state or federal departments; or

(vi) any marketing component that displays the name of the carrier, or that is paid for by the carrier to any affiliate of the carrier in any way, either directly or indirectly.

(e) "Premium revenue" means the sum of all monies paid by enrollees to receive coverage from a dental insurer or health insurer. This amount shall reconcile to the NAIC Accident and Health Policy Experience ~~Life Insurance State Page for Montana, or the NAIC~~ Exhibit of ~~Premiums, Enrollment and Utilization, as applicable, for insurance companies filing on an NAIC life insurance~~ the annual statement filing. ~~or an NAIC health insurance annual statement, respectively.~~ The following distinctions apply:

(i) Premium revenue excludes adjustments for retroactive rate reductions.

(ii) Premium revenue is to be reported before any deduction of premium discounts granted to enrollees.

(iii) Premium revenue should be the direct premium received (excluding reinsurance).

(f) "Overhead and administrative cost expenditures" are based on the generally accepted accounting principles (GAAP). Examples of overhead expenditures include:

(i) rent;

(ii) legal fees and expenses;

(iii) professional consulting fees;

(iv) travel expenditures; and

(v) utility expenditures.

(g) Examples of "administrative cost expenditures" include:

(i) activities designed primarily to control or contain costs;

(ii) establishing or maintaining a claims adjudication system, including upgrades in information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims;

(iii) retrospective and concurrent utilization review, and any prospective utilization review that cannot be specifically justified as meeting the definition of "activities that improve dental care quality";

(iv) fraud prevention activities;

(v) developing and executing provider contracts, including establishing or managing a provider network;

(vi) provider credentialing;

(vii) payroll, except for positions dedicated to activities that improve oral and overall health and the pro rata share of payroll for positions substantially involved in such activities;

(viii) marketing expenses;

(ix) calculating and administering individual enrollee or employee incentives unless used in the promotion of activities that improve oral and overall health;

(x) direct sales salaries, workforce salaries, and benefits; and

(xi) agents and brokers fees and commissions~~;~~.

(h) "Federal and state taxes, licensing and regulatory fees" means taxes, licensing, and regulatory fees allocated to dental insurance coverage that meet the CFR criteria for reporting of federal and state taxes, 45 CFR 158.162(a) and (b). Allocation methods must follow one of the methods described in 45 CFR 158.170(a) and (b) and must be disclosed on the dental loss ratio reporting template. Fines and penalties of regulatory authorities, and fees for examinations by state and federal departments, other than those referenced in 45 CFR 158.162(b), may not be used as an adjustment to premium revenue and must be separately reported.

Authorizing statute(s): 33-22-2204, 33-22-2205, MCA

Implementing statute(s): 33-22-2202, 33-22-2204, 33-22-2205, MCA

NEW RULE 2 (6.6.9202) DENTAL LOSS RATIO REPORTING REQUIREMENTS

(1) For purposes of the dental loss ratio annual report specified in 33-22-2203, MCA, on or before December 31, 2026, and each year thereafter, the commissioner will publish on the commissioner's website a dental loss ratio annual report template

and instructions for ~~submission to~~ use by dental ~~insurance~~ insurers licensed in Montana.

(2) On or before March 1, 2027, an insurer that offers a dental coverage plan covered by the Montana Dental Insurance Transparency and Accountability Act, 33-22-2201, et seq., MCA, (dental carrier) shall electronically file a completed dental loss ratio report for reporting years 2025 and 2026 (two years). This data will be published in accordance with 33-22-2203(3) and (4), MCA, for ~~both~~ public use and will be provided to the economic affairs interim committee~~;~~. ~~however~~ However, an average dental loss ratio shall not be calculated.

(3) On or before March 1, 2028, and on or before March 1 each year thereafter, each dental carrier shall electronically file a completed dental loss ratio report for the preceding reporting year. The calculated dental loss ratio and each data element described in the loss ratio calculation shall be reported for each market segment (e.g., individual, small group, or large group market) offered by the carrier.

(4) After the data is submitted for reporting year 2027, the commissioner will calculate an average dental loss ratio for each market segment using the aggregate data for reporting years 2025, 2026, and 2027. For each subsequent year, the commissioner will calculate an average dental loss ratio based on the most recent three years of data. Additionally, the data will be published in accordance with 33-22-2203(3) and (4), MCA, for public use and will be provided to the economic affairs interim committee.

(5) The dental loss ratio report will require dental carriers to report the number of covered lives and the components of the dental loss ratio calculation separately for Montana ~~and nationwide~~ market segment experience in the dental loss ratio reporting template. For each dental coverage plan that exceeds 250 covered lives, the dental carrier shall report the following additional data elements:

(a) the plan cost-sharing and deductible amounts;

(b) the annual maximum coverage limit; and

(c) the number of covered lives who met or exceeded the annual coverage limit.

(6) Dental carriers that purchase a line or block of business from another carrier during a reporting year must submit the required dental loss ratio reporting information for the assumed business, including for that part of the reporting year that preceded the purchase.

Authorizing statute(s): 33-22-2204, 33-22-2205, MCA

Implementing statute(s): 33-22-2202, 33-22-2204, 33-22-2205, MCA

Statement of Reasons

The agency has considered the comments and testimony received. A summary of the comments received, and the agency's responses are as follows:

Comment 1: "SB 335 has an effective date of January 1 2026. Section 3 of SB 335 requires insurers to compile certain data and provide CSI with a medical dental loss ratio (DLR) report. The DLR must be for the policy year during which the insurer provided dental coverage.

The obligation to report does not start until January 1, 2026, thus a 'policy year' cannot be earlier than 2026 and the DLR would be filed with the insurer annual statement for 2026 due March 1, 2027. '[Insurer] shall file by March 1 of each year with its annual statement a medical dental loss ratio report with the commissioner of securities.' Section 3 SB 335."

Response 1: CSI appreciates the comment and agrees that reporting will not begin until March 1, 2027. In accordance with the statute's intention, the final rule requires that data for reporting years 2025 and 2026 shall be submitted by March 1, 2027. CSI will utilize this data for purposes of preparing a report for public use in accordance with statutory requirements.

Comment 2: "We disagree with the assessment of how to 'calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period, including data for the most recent dental loss ratio reporting year and the data for the two prior dental loss ratio reporting years.' We believe the law is clear that the 'most recent dental loss ratio reporting year' will be 2026 and the 'two prior dental loss ratio reporting years' will be 2024 and 2025. Therefore, under New Rule 2(2), on or before March 1, 2027, an insurer would file for reporting years, 2024, 2025, and 2026 and an average dental loss ratio would be calculated based on those years.

We submit that this is the only appropriate interpretation of SB335, and failure to calculate and publish an average dental loss ratio beginning in 2027 for the three prior years would run afoul of SB335's mandate. SB335, Section 4, requires that the 'commissioner shall calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period…' As currently drafted, New Rule 2(2) appears to violate this express requirement by stating as of March 1, 2027 'an average dental loss ratio shall not be calculated.' This statement is in direct conflict with SB335, Section 4's requirement that a dental loss ratio 'shall' be calculated each year, and 'shall' use three years of data. We submit this interpretation is in line with the purpose section of the statute, which is to ensure transparency to the public and fairness to covered individuals."

Response 2: SB 335 requires that dental insurers file an annual medical dental loss ratio report with the commissioner by March 1 of each year. SB 335 does not require dental insurers to file dental loss ratio reports for years prior to the laws' applicability date of January 1, 2026. While

SB 335 requires the commissioner to calculate an average dental loss ratio for a three-year period to include the most recent dental loss ratio reporting year and for the two prior dental loss ratio reporting years, SB 335 does not stipulate a retroactive applicability date. Therefore, NEW RULE 2(2) is within the scope of SB 335's mandate.

Comment 3: "We believe rules should be adopted for Section 4 of SB 335 pertaining to excess revenue – rebate. That section does allow rules to be promulgated and it would not be difficult to do so, based on similarities to the Affordable Care Act. We believe this will avoid confusion and misinterpretation in the future."

Response 3: CSI appreciates the comment to adopt additional rules specific to the rebate of excess revenues. This is outside the scope of the current rulemaking.

Comment 4: "We respectfully request that the Commissioner revise Rule 1(1)(e) and Rule 2(5) to reconsider reporting requirements that go beyond what is necessary to implement Montana's dental loss ratio statute.

In particular, Rule 1(1)(e) would require premium revenue to reconcile reports that use a different geographic attribution methodology, creating the potential for unavoidable discrepancies even when a carrier's DLR reporting is accurate. To better align reporting requirements with how group dental plans are administered, we recommend allowing reconciliation to the NAIC Accident and Health Policy Experience Exhibit rather than reports that allocate premium by member residency, as DLR reporting is conducted at the employer group level. We also recommend limiting reporting to Montana-specific experience, as the requirement to report nationwide market segment data adds administrative complexity without a corresponding state regulatory benefit."

Response 4: CSI appreciates this comment and concurs. The final rule makes the change to use the Accident and Health Policy Experience Exhibit as the source of reconciliation. In addition, after careful consideration, we have updated NEW RULE 2 to remove the requirement to report nationwide dental loss ratio data given that 33-22-2203, MCA, only requires reporting a Montana loss ratio calculation.

Comment 5: "We believe that more granular reporting would not necessarily result in more meaningful oversight. Requiring the statutorily identified data elements to be reported at the individual plan level would not materially enhance the Commissioner's ability to assess DLR compliance, improve consumer understanding, expand access to care, promote affordability of coverage, or improve oral health outcomes for Montanans. Rather, it would create confidentiality risks, invite potentially misleading comparisons across differing plan designs, and divert resources from activities more directly connected to oral health access and consumer value.

We recommend a more targeted and appropriately tailored reporting approach. Rule 1(1)(e) should permit reconciliation to the NAIC Accident and Health Policy Experience Exhibit, which more closely aligns with the group-level reporting methodology used in DLR calculations.

In addition, if the Commissioner determines that supplemental information is necessary to implement SB 335, Montana's proposed rule appears to rely heavily on Colorado's dental loss ratio regulation, which limits additional data elements to a carrier's top ten dental plans in each market segment."

Response 5: CSI appreciates the comment regarding data elements and plan level reporting. CSI believes that the plan level data specified is meaningful information. The proposed rule indicates the data will be provided for each plan that covers a minimum of 250 lives, which excludes plans of a size that may not provide credible data. CSI will consider adjustments for credibility criteria once adequate reporting is available to make a reasonable assessment.

CSI will comply with 33-22-2203, MCA, in reporting data to the public. To the extent that confidentiality concerns remain, CSI is willing to evaluate those on an individual basis.

Comment 6: "New Rule 1, section (1)(e) states the premium revenue shall reconcile to the NAIC Life Insurance State Page for Montana, or the NAIC Exhibit of Premiums, Enrollment, and Utilization. The NAIC filings are based off member residency while DLR reporting will be based on the employer contact location - that is, the location where the employer-sponsored dental plan is administered - not the member's individual residency. This approach is consistent with how medical loss ratio (MLR) reporting works for group health plans - MLR is calculated at the group level using premiums and claims associated with the group's defined market segment, rather than individual member residency.

We propose the DLR premium should reconcile to the Accident and Health Policy Experience Exhibit. This exhibit provides a more appropriate basis for reconciliation, as it better aligns with group-level reporting and reflects the underlying structure used in DLR calculations."

Response 6: CSI appreciates this comment and concurs. The final rule makes the change to use the Accident and Health Policy Experience Exhibit as the source of reconciliation.

Comment 7: "New Rule 2, section (5) mentions carriers are to report components of the dental loss ratio calculation for Montana as well as nationwide.

We recommend reconsidering the requirement to include nationwide market segment data. Collecting and reporting nationwide information introduces additional operational complexity and administrative burden for carriers, with unclear regulatory benefit at the state level. We note that other states have begun to move away from this approach (e.g., recent changes in Colorado DLR), suggesting that nationwide reporting may not provide meaningful value for state-specific oversight. Accordingly, limiting reporting to Montana-specific experience would improve efficiency while still meeting the State's regulatory objectives."

Response 7: CSI appreciates this comment. After consideration, we have updated NEW RULE 2 to remove the requirement to report nationwide dental loss ratio data given that 33-22-2203, MCA, only requires reporting a Montana loss ratio calculation.

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Approval

James Brown, State Auditor