

HOUSE No. 3557

The Commonwealth of Massachusetts

PRESENTED BY:

Kevin G. Honan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to transparency of dental benefits corporations.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Kevin G. Honan</i>	<i>17th Suffolk</i>
<i>Harriette L. Chandler</i>	<i>First Worcester</i>
<i>David F. DeCoste</i>	<i>5th Plymouth</i>
<i>Steven S. Howitt</i>	<i>4th Bristol</i>
<i>David Henry Argosky LeBoeuf</i>	<i>17th Worcester</i>

HOUSE No. 3557

By Mr. Honan of Boston, a petition (accompanied by bill, House, No. 3557) of Kevin G. Honan and others relative to dental insurance benefit plans. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

An Act relative to transparency of dental benefits corporations.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. The General Laws are hereby amended by inserting after chapter 176U the
2 following chapter:-

3 Chapter 176V

4 Dental Benefit Plans

5 Section 1. As used in this chapter the following words shall, unless the context clearly
6 requires otherwise, have the following meanings:-

7 “Carrier”, any insurer licensed or otherwise authorized to transact accident and health
8 insurance under chapter 175, non-profit medical service corporation under chapter 176B; a
9 dental service corporation organized under chapter 176E, health maintenance organization
10 organized under chapter 176G, or preferred provider arrangement organized under chapter 176I
11 offering dental benefit plans in the commonwealth.

12 “Commissioner”, the commissioner of the division of insurance.

13 “Connector”, the commonwealth health insurance connector, established by chapter
14 176Q.

15 “Dental benefit plans”, any stand-alone dental plan that covers oral surgical care,
16 services, procedures or benefits covered by any individual, general, blanket or group policy of
17 health, accident and sickness insurance issued by an insurer licensed or otherwise authorized to
18 transact accident and health insurance under chapter 175; any oral surgical care, services,
19 procedures or benefits covered by a stand-alone individual or group dental medical service plan
20 issued by a non-profit medical service corporation under chapter 176B; any oral surgical care,
21 services, procedures or benefits covered by a stand-alone individual or group dental service plan
22 issued by a dental service corporation organized under chapter 176E; any oral surgical care,
23 services, procedures or benefits covered by a stand-alone individual or group dental health
24 maintenance contract issued by a health maintenance organization organized under chapter
25 176G; or any oral surgical care, services, procedures or benefits covered by a stand-alone
26 individual or group preferred provider dental plan issued by a preferred provider arrangement
27 organized under chapter 176I.

28 “Self-insured customer”, a self-insured group for which a carrier provides administrative
29 services.

30 “Self-insured group”, a self-insured or self-funded employer group health plan.

31 “Third-party administrator”, a person who, on behalf of a dental insurer or purchaser of
32 dental benefits, receives or collects charges, contributions or premiums for, or adjusts or settles
33 claims on or for residents of the commonwealth.

34 Section 2. Except as otherwise provided, this chapter applies to all dental benefit plans
35 issued, made effective, delivered or renewed after April 1, 2019 whether issued directly by a
36 carrier, through the connector, or through an intermediary, excepting those plans issued,
37 delivered or renewed to a self-insured group or where the carrier is acting as a third-party
38 administrator. Nothing in this chapter shall be construed to require a carrier that does not issue
39 dental benefit plans subject to this chapter to issue dental benefit plans subject to this chapter.

40 Section 3. (a) Notwithstanding any general or special law to the contrary, the
41 commissioner may approve dental benefit policies submitted to the division of insurance for the
42 purpose of being provided to individuals and groups. These dental benefit policies shall be
43 subject to this chapter and may include networks that differ from those of a dental plan's overall
44 network. The commissioner shall adopt regulations regarding eligibility criteria.

45 (b) Notwithstanding any general or special law to the contrary, the commissioner shall
46 require carriers offering dental benefit plans to submit information as required by the
47 commissioner, which shall include the current and projected medical loss ratio for plans the
48 components of projected administrative expenses and financial information, including, but not
49 limited to: (i) underwriting, auditing, actuarial, financial analysis, treasury and investment
50 expenses; (ii) marketing and sales expenses, including but not limited to, advertising, member
51 relations, member enrollment and all expenses associated with producers, brokers and benefit
52 consultants; (iii) claims operations expenses, including, but not limited to, adjudication, appeals,
53 settlements and expenses associated with paying claims;

54 (iv) dental administration expenses, including, but not limited to, disease management,
55 utilization review and dental management; (v) network operations expenses, including, but not

56 limited to, contracting and dentist relations and dental policy procedures; (vi) charitable
57 expenses, including, but not limited to, contributions to tax-exempt foundations and community
58 benefits; (vii) state premium taxes; (viii) board, bureau and association fees; (ix) depreciation;
59 and (x) miscellaneous expenses described in detail by expense, including any expense not
60 included in clauses (i) to (ix), inclusive.

61 (c) Notwithstanding any general or special law to the contrary, carriers offering dental
62 benefit plans, including carriers licensed under chapters 175, 176B, 176E, 176G or 176I, shall
63 file group product base rates and any changes to group rating factors that are to be effective on
64 January 1 of each year, on or before July 1 of the preceding year. The commissioner shall
65 disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in
66 relation to the benefits charged. The commissioner shall disapprove any change to group rating
67 factors that is discriminatory or not actuarially sound. Rates of reimbursement or rating factors
68 included in the rate filing materials submitted for review by the division shall be deemed
69 confidential and exempt from the definition of public records in clause Twenty-sixth of section 7
70 of chapter 4. The commissioner shall adopt regulations to carry out this section.

71 (d) If a proposed rate change has been presumptively disapproved:

72 (i) a carrier shall communicate to all employers and individuals covered under a group
73 product that the proposed increase has been presumptively disapproved and is subject to a
74 hearing at the division of insurance;

75 (ii) the commissioner shall conduct a public hearing and shall advertise that hearing in
76 newspapers in the cities of Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New
77 Bedford and Lowell, or shall notify such newspapers of the hearing; and

78 (iii) the attorney general may intervene in a public hearing or other proceeding under this
79 section and may require additional information as the attorney general considers necessary to
80 ensure compliance with this subsection.

81 The commissioner shall adopt regulations to specify the scheduling of the hearings
82 required under this section.

83 (e) If the commissioner disapproves the rate submitted by a carrier the commissioner
84 shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the
85 carrier's rate. The carrier may submit a request for hearing to the division of insurance within 10
86 days of such notice of disapproval. The division must schedule a hearing within 15 days of
87 receipt. The commissioner shall issue a written decision within 30 days after the conclusion of
88 the hearing. The carrier may not implement the disapproved rates, or changes at any time unless
89 the commissioner reverses the disapproval after a hearing or unless a court vacates the
90 commissioner's decision.

91 Section 4. (a) Each carrier shall submit an annual comprehensive financial statement to
92 the division detailing carrier costs from the previous calendar year. The annual comprehensive
93 financial statement shall include all of the information in this section and shall be itemized,
94 where applicable, by:

95 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25, and
96 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

97 (ii) line of business, including any stand-alone dental plan that covers oral surgical care,
98 services, procedures or benefits covered by any individual, general, blanket or group policy of
99 health, accident and sickness insurance issued by an insurer licensed or otherwise authorized to

100 transact accident and health insurance under chapter 175; any oral surgical care, services,
101 procedures or benefits covered by a stand-alone individual or group dental medical service plan
102 issued by a non-profit medical service corporation under chapter 176B; any oral surgical care,
103 services, procedures or benefits covered by a stand-alone individual or group dental service plan
104 issued by a dental service corporation organized under chapter 176E; any oral surgical care,
105 services, procedures or benefits covered by a stand-alone individual or group dental health
106 maintenance contract issued by a health maintenance organization organized under chapter
107 176G; or any oral surgical care, services, procedures or benefits covered by a stand-alone
108 individual or group preferred provider dental plan issued by a preferred provider arrangement
109 organized under chapter 176I; and stand-alone dental group health insurance plans issued by the
110 commission under chapter 32A.

111 The statement shall include, but shall not be limited to, the following information:

112 (i) direct premiums earned, as defined in chapter 176J; direct claims incurred, as defined
113 in said chapter 176J; (ii) medical loss ratio; (iii) number of members;

114 (iv) number of distinct groups covered; (v) number of lives covered; (vi) realized capital
115 gains and losses; (viii) net income; (ix) accumulated surplus; (x) accumulated reserves; (xi) risk-
116 based capital ratio, based on a formula developed by the National Association of Insurance
117 Commissioners; (xii) financial administration expenses, including underwriting, auditing,
118 actuarial, financial analysis, treasury and investment purposes; (xiii) marketing and sales
119 expenses, including advertising, member relations, member enrollment expenses; (xiv)
120 distribution expenses, including commissions, producers, broker and benefit consultant expenses;
121 (xv) claims operations expenses, including adjudication, appeals, settlements and expenses

122 associated with paying claims; (xvi) dental administration expenses, including disease
123 management, utilization review and dental management expenses; (xvii) network operational
124 expenses, including contracting, dentist relations and dental policy procedures; (xviii) charitable
125 expenses, including any contributions to tax-exempt foundations and community benefits; (xix)
126 board, bureau or association fees;

127 (xx) any miscellaneous expenses described in detail by expense, including an expense not
128 included in (i) to (xix), inclusive; (xxi) payroll expenses and the number of employees on the
129 carrier's payroll; (xxii) taxes, if any, paid by the carrier to the federal government or to the
130 commonwealth; and (xxiii) any other information deemed necessary by the commissioner.

131 (b) Any carrier required to report under this section, which provides administrative
132 services to 1 or more self-insured groups shall include, as an appendix to such report, the
133 following information: (i) the number of the carrier's self-insured customers;

134 (ii) the aggregate number of members, as defined in section 1 of chapter 176J, in all of
135 the carrier's self-insured customers; (iii) the aggregate number of lives covered in all of the
136 carrier's self-insured customers; (iv) the aggregate value of direct premiums earned, as defined in
137 said chapter 176J, for all of the carrier's self-insured customers;

138 (v) the aggregate medical loss ratio, as defined in said chapter 176J, for all of the
139 carrier's self-insured customers; (vi) net income; (vii) accumulated surplus; (ix) accumulated
140 reserves; (x) the percentage of the carrier's self-insured customers that include each of the
141 benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G; (xi)
142 administrative service fees paid by each of the carrier's self-insured customers; and (xii) any
143 other information deemed necessary by the commissioner.

144 (c) A carrier who fails to file this report on or before April 1 shall be assessed a late
145 penalty not to exceed \$100 per day. The division shall make public all of the information
146 collected under this section. The division shall issue an annual summary report to the joint
147 committee on financial services, the joint committee on health care financing and the house and
148 senate committees on ways and means of the annual comprehensive financial statements by May
149 15. The information shall be exchanged with the center for health information and analysis for
150 use under section 10 of chapter 12C. The division shall, from time to time, require payers to
151 submit the underlying data used in their calculations for audit.

152 The commissioner shall adopt rules to carry out this subsection, including standards and
153 procedures requiring the registration of persons or entities not otherwise licensed or registered by
154 the commissioner, such as third-party administrators, and criteria for the standardized reporting
155 and uniform allocation methodologies among carriers. The division shall, before adopting
156 regulations under this section, consult with other agencies of the commonwealth and the federal
157 government and affected carriers to ensure that the reporting requirements imposed under the
158 regulations are not duplicative.

159 (d) If, in any year, a carrier reports a risk-based capital ratio on a combined entity basis
160 under subsection (a) that exceeds 700 percent, the division shall hold a public hearing within 60
161 days. The carrier shall submit testimony on its overall financial condition and the continued need
162 for additional surplus. The carrier shall also submit testimony on how, and in what proportion to
163 the total surplus accumulated, the carrier will dedicate any additional surplus to reducing the cost
164 of dental benefit plans or for dental care quality improvement, patient safety, or dental cost
165 containment activities not conducted in previous years. The division shall review such testimony
166 and issue a final report on the results of the hearing.

167 (e) The commissioner may waive specific reporting requirements in this section for
168 classes of carriers for which the commissioner deems such reporting requirements to be
169 inapplicable; provided, however, that the commissioner shall provide written notice of any such
170 waiver to the joint committee on health care financing and the house and senate committees on
171 ways and means.

172 SECTION 2. Notwithstanding any special or general law to the contrary, the division of
173 insurance, in consultation with the center for health information and analysis, shall promulgate
174 regulations on or before January 1, 2019 to establish a uniform methodology for calculating and
175 reporting by carriers for the medical loss ratios of dental benefit plans under section 2 of chapter
176 176V and section 6 of chapter 12C of the General Laws. The uniform methodology for
177 calculating and reporting medical loss ratios shall, at a minimum, specify a uniform method for
178 determining whether and to what extent an expenditure shall be considered a dental claims
179 expenditure or an administrative cost expenditure, which shall include, but not be limited to, a
180 determination of which of these classes of expenditures the following expenses fall into: (i)
181 financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses;
182 (iv) claims operations expenses; (v) dental administration expenses, such as disease
183 management, care management, utilization review and dental management activities; (vi)
184 network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees;
185 (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other
186 miscellaneous expenses not included in one of the previous categories. The methodology shall
187 conform with applicable federal statutes and regulations to the extent possible. The division
188 shall, before adopting regulations under this section, consult with: the group insurance
189 commission; the Centers for Medicare and Medicaid Services; the national association of

190 insurance commissioners; the attorney general; representatives from the Massachusetts
191 Association of Health Plans; the Massachusetts Dental Society; Health Care for All, Inc.; and a
192 representative from a small business association.

193 SECTION 3. Any domestic company that is authorized to offer health benefit plans under
194 chapters 175, 176A, 176B and 176G and that contract with dentists shall be subject to the
195 following requirements:

196 (a) The form of the agreement between the company and dentists shall at all times be
197 subject to the written approval of the commissioner of the Division of Insurance;

198 (b) The fees to be paid by the company to dentists with which it contracts shall at all
199 times be subject to a public hearing as provided by section 2 of chapter 30A and to the written
200 approval of the commissioner;

201 (c) Any registered dentist shall have the right, on complying with such rules and
202 regulations as the company may make, to enter into a written agreement with such company,
203 doing business in the city or town the dentist resides or has a usual place of business to perform
204 dental services;

205 (d) This chapter shall not change the normal relations between a dentist and patient
206 except as to the manner and amount of fees which are to be paid by such company to the dentist
207 on behalf of the member;

208 (e) No restriction shall be placed by any such corporation upon a dentist as to
209 methods of diagnosis, treatment or referrals to other dentists or other health care practitioners;

210 (f) No officer, agent or employee of such company shall influence or attempt to
211 influence a member's choice of dentist; and

212 (g) Such company shall not condition its willingness to allow a registered dentist to
213 participate in any product, network, contract, or arrangement offered by the company that is not a
214 preferred provider arrangement, as defined by chapter 176I, on such dentist agreeing to enter into
215 a preferred provider arrangement with the company.

216 SECTION 4. Section 108B of Chapter 175 of the General Laws, as appearing in the 2018
217 Official Edition, is hereby amended by inserting at the end of said section the following: -

218 1. For the purposes of this section, "contracting entity" means any person or entity
219 that is engaged in the act of contracting with a registered dentist and has a direct contract with a
220 registered dentist for the delivery of healthcare services or benefits or the selling, renting,
221 leasing, or granting access of dental networks to other healthcare entities. "Third-party" means
222 any person or entity that enters into a contract with a contracting entity or with another third-
223 party to gain access to a provider network contract or dental network contract

224 2. a. Except as otherwise provided in subsection b. of this section, a contracting
225 entity shall not sell, rent, lease or grant access to:

226 1. A dental network contract or provider network contract;

227 2. A dentist's healthcare services and contractual discounts pursuant to a network
228 contract

229 b. A contracting entity may grant a third-party access to a contract, or services or
230 discounts pursuant to a contract as specified in subsection a. of this section, if the contracting
231 entity delivers a written request to the dentist to grant the third-party access to that contract.

232 1. The dentist gives the contracting entity express written consent to grant the third-
233 party access to the contract; or

234 2. 90 days expire from the time the dentist receives the written request and the dentists
235 does not give the contracting entity an express written denial of consent to grant the third-party
236 access to the contract.

237 3. Any third-party buying, renting, leasing or gaining access to a dental network or
238 provider network from a contracting entity shall pay the dentist's discounted rates or fees in
239 accordance with the terms and conditions set forth in the contract between the contracting entity
240 and such provider.

241 SECTION 5. Section 7 of chapter 176B of the General Laws, as appearing in the 2018
242 Official Edition, is hereby amended by inserting after the second paragraph the following
243 paragraph: -

244 1. For the purposes of this section, "contracting entity" means any person or entity
245 that is engaged in the act of contracting with a registered dentist and has a direct contract with a
246 registered dentist for the delivery of healthcare services or benefits or the selling, renting,
247 leasing, or granting access of dental networks to other healthcare entities. "Third-party" means
248 any person or entity that enters into a contract with a contracting entity or with another third-
249 party to gain access to a provider network contract or dental network contract

250 2. a. Except as otherwise provided in subsection b. of this section, a contracting
251 entity shall not sell, rent, lease or grant access to:

252 1. A dental network contract or provider network contract;

253 2. A dentist’s healthcare services and contractual discounts pursuant to a network
254 contract

255 b. A contracting entity may grant a third-party access to a contract, or services or
256 discounts pursuant to a contract as specified in subsection a. of this section, if the contracting
257 entity delivers a written request to the dentist to grant the third-party access to that contract.

258 1. The dentist gives the contracting entity express written consent to grant the third-party
259 access to the contract; or

260 2. 90 days expire from the time the dentist receives the written request and the dentists
261 does not give the contracting entity an express written denial of consent to grant the third-party
262 access to the contract.

263 3. Any third-party buying, renting, leasing or gaining access to a dental network or
264 provider network from a contracting entity shall pay the dentist’s discounted rates or fees in
265 accordance with the terms and conditions set forth in the contract between the contracting entity
266 and such provider.

267 SECTION 6. Section 7 of chapter 176E of the General Laws, as appearing in the 2018
268 Official Edition, is hereby amended by inserting after the second paragraph the following
269 paragraph:

270 1. For the purposes of this section, “contracting entity” means any person or entity
271 that is engaged in the act of contracting with a registered dentist and has a direct contract with a
272 registered dentist for the delivery of healthcare services or benefits or the selling, renting,
273 leasing, or granting access of dental networks to other healthcare entities. ”Third-party” means
274 any person or entity that enters into a contract with a contracting entity or with another third-
275 party to gain access to a provider network contract or dental network contract

276 2. a. Except as otherwise provided in subsection b. of this section, a contracting
277 entity shall not sell, rent, lease or grant access to:

278 3. A dental network contract or provider network contract;

279 4. A dentist’s healthcare services and contractual discounts pursuant to a network
280 contract

281 b. A contracting entity may grant a third-party access to a contract, or services or
282 discounts pursuant to a contract as specified in subsection a. of this section, if the contracting
283 entity delivers a written request to the dentist to grant the third-party access to that contract.

284 1. The dentist gives the contracting entity express written consent to grant the third-party
285 access to the contract; or

286 2. 90 days expire from the time the dentist receives the written request and the dentists
287 does not give the contracting entity an express written denial of consent to grant the third-party
288 access to the contract.

289 3. Any third-party buying, renting, leasing or gaining access to a dental network or
290 provider network from a contracting entity shall pay the dentist’s discounted rates or fees in

291 accordance with the terms and conditions set forth in the contract between the contracting entity
292 and such provider.

293 SECTION 7. Section 21 of chapter 176G of the General Laws, as appearing in the 2018
294 Official Edition, is hereby amended by inserting after sub-section (d) the following sub-section:

295 (e)

296 1. For the purposes of this section, “contracting entity” means any person or entity
297 that is engaged in the act of contracting with a registered dentist and has a direct contract with a
298 registered dentist for the delivery of healthcare services or benefits or the selling, renting,
299 leasing, or granting access of dental networks to other healthcare entities. ”Third-party” means
300 any person or entity that enters into a contract with a contracting entity or with another third-
301 party to gain access to a provider network contract or dental network contract

302 2. a. Except as otherwise provided in subsection b. of this section, a contracting
303 entity shall not sell, rent, lease or grant access to:

304 5. A dental network contract or provider network contract;

305 6. A dentist’s healthcare services and contractual discounts pursuant to a network
306 contract

307 b. A contracting entity may grant a third-party access to a contract, or services or
308 discounts pursuant to a contract as specified in subsection a. of this section, if the contracting
309 entity delivers a written request to the dentist to grant the third-party access to that contract.

310 1. The dentist gives the contracting entity express written consent to grant the third-party
311 access to the contract; or

312 2. 90 days expire from the time the dentist receives the written request and the dentists
313 does not give the contracting entity an express written denial of consent to grant the third-party
314 access to the contract.

315 3. Any third-party buying, renting, leasing or gaining access to a dental network or
316 provider network from a contracting entity shall pay the dentist's discounted rates or fees in
317 accordance with the terms and conditions set forth in the contract between the contracting entity
318 and such provider.

319 SECTION 8. Section 2 of chapter 176I of the General Laws, as appearing in the 2018
320 Official Edition, is hereby amended by inserting after the first paragraph the following
321 paragraph: - “

322 1. For the purposes of this section, “contracting entity” means any person or entity
323 that is engaged in the act of contracting with a registered dentist and has a direct contract with a
324 registered dentist for the delivery of healthcare services or benefits or the selling, renting,
325 leasing, or granting access of dental networks to other healthcare entities. ”Third-party” means
326 any person or entity that enters into a contract with a contracting entity or with another third-
327 party to gain access to a provider network contract or dental network contract

328 2. a. Except as otherwise provided in subsection b. of this section, a contracting
329 entity shall not sell, rent, lease or grant access to:

330 7. A dental network contract or provider network contract;

331 8. A dentist's healthcare services and contractual discounts pursuant to a network
332 contract

333 b. A contracting entity may grant a third-party access to a contract, or services or
334 discounts pursuant to a contract as specified in subsection a. of this section, if the contracting
335 entity delivers a written request to the dentist to grant the third-party access to that contract.

336 1. The dentist gives the contracting entity express written consent to grant the third-party
337 access to the contract; or

338 2. 90 days expire from the time the dentist receives the written request and the dentists
339 does not give the contracting entity an express written denial of consent to grant the third-party
340 access to the contract.

341 3. Any third-party buying, renting, leasing or gaining access to a dental network or
342 provider network from a contracting entity shall pay the dentist's discounted rates or fees in
343 accordance with the terms and conditions set forth in the contract between the contracting entity
344 and such provider