SENATE DOCKET, NO. 289 FILED ON: 1/11/2019

SENATE . . . . . No. 544

The Commonwealth of Massachusetts

PRESENTED BY:

Harriette L. Chandler

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:	
Harriette L. Chandler	*First Worcester*	
Kevin G. Honan	*17th Suffolk*	
David Henry Argosky LeBoeuf	*17th Worcester*	*2/26/2019*

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SENATE . . . . . No. 544

By Ms. Chandler, a petition (accompanied by bill, Senate, No. 544) of Harriette L. Chandler, Kevin G. Honan and David Henry Argosky LeBoeuf for legislation relative to transparency of dental benefits corporations. 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:

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

Chapter 176V

Dental Benefit Plans

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

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

"Commissioner", the commissioner of the division of insurance.

"Connector", the commonwealth health insurance connector, established by chapter 176Q.

"Dental benefit plans", any stand-alone dental plan that covers oral surgical care, services, procedures or benefits covered by any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; any oral surgical care, services, procedures or benefits covered by a stand-alone individual or group dental medical service plan issued by a non-profit medical service corporation under chapter 176B; any oral surgical care, services, procedures or benefits covered by a stand-alone individual or group dental service plan issued by a dental service corporation organized under chapter 176E; any oral surgical care, services, procedures or benefits covered by a stand-alone individual or group dental health maintenance contract issued by a health maintenance organization organized under chapter 176G; or any oral surgical care, services, procedures or benefits covered by a stand-alone individual or group preferred provider dental plan issued by a preferred provider arrangement organized under chapter 176I.

"Self-insured customer", a self-insured group for which a carrier provides administrative services.

"Self-insured group", a self-insured or self-funded employer group health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A dental network contract or provider network contract;

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

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

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

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

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

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

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

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

1. A dental network contract or provider network contract;

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

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

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

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

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

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

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

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

3. A dental network contract or provider network contract;

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

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

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

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

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

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

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

(e)

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

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

5. A dental network contract or provider network contract;

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

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

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

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

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

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

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

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

7. A dental network contract or provider network contract;

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

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

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

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

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