

SENATE No. 566

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 dental benefit plan transparency and patients' Bill of Rights.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Harriette L. Chandler</i>	<i>First Worcester</i>
<i>John W. Scibak</i>	<i>2nd Hampshire</i>
<i>Ruth B. Balsler</i>	<i>12th Middlesex</i>
<i>Diana DiZoglio</i>	<i>14th Essex</i>
<i>Sal N. DiDomenico</i>	<i>Middlesex and Suffolk</i>

SENATE No. 566

By Ms. Chandler, a petition (accompanied by bill, Senate, No. 566) of Harriette L. Chandler, John W. Scibak, Ruth B. Balser, Diana DiZoglio and others for legislation relative to dental benefit plan transparency and patients' Bill of Rights. Health Care Financing.

The Commonwealth of Massachusetts

**In the One Hundred and Eighty-Ninth General Court
(2015-2016)**

An Act relative to dental benefit plan transparency and patients' Bill of Rights.

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, 2015 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 chapters 175, 176B, 176E, 176G or 176I, shall file
63 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 carrier files a base rate change under this section and the administrative expense
72 loading component, not including taxes and assessments, increases by more than the most recent
73 calendar year's percentage increase in the New England dental CPI or if a carrier's reported
74 contribution to surplus exceeds 1.9 per cent or if the aggregate medical loss ratio for all plans
75 offered under this chapter is less than the applicable percentage set forth in subsection (e), then
76 such carrier's rate, in addition to being subject to all other provisions of this chapter, shall be
77 presumptively disapproved as excessive by the commissioner as set forth in this subsection.

78 If the annual aggregate medical loss ratio for all plans offered under this chapter is less
79 than the applicable percentage set forth in subsection (e) the carrier shall refund the excess
80 premium to its covered individuals and covered groups. A carrier shall communicate within 30
81 days to all individuals and groups that were covered under plans during the relevant 12-month
82 period that such individuals and groups qualify for a refund on the premium for the applicable
83 12-month period or, if the individual or groups are still covered by the carrier, a credit on the
84 premium for the subsequent 12-month period. The total of all refunds issued shall equal the
85 amount of a carrier's earned premium that exceeds that amount necessary to achieve a medical
86 loss ratio of the applicable percentage set forth in subsection (e), calculated using data reported
87 by the carrier as prescribed under regulations promulgated by the commissioner. The
88 commissioner may authorize a waiver or adjustment of this requirement only if it is determined
89 that issuing refunds would result in financial impairment for the carrier.

90 (e) The medical loss ratio set forth in subsection (d) shall be 90 per cent for the period
91 through December 31, 2016. The medical loss ratio set forth in subsection (d) shall be 95 per
92 cent for the period from January 1, 2017 forward.

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

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

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

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

103 The commissioner shall adopt regulations to specific the scheduling of the hearings
104 required under this section.

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

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

117 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25, and
118 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

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

122 transact accident and health insurance under chapter 175; any oral surgical care, services,
123 procedures or benefits covered by a stand-alone individual or group dental medical service plan
124 issued by a non-profit medical service corporation under chapter 176B; any oral surgical care,
125 services, procedures or benefits covered by a stand-alone individual or group dental service plan
126 issued by a dental service corporation organized under chapter 176E; any oral surgical care,
127 services, procedures or benefits covered by a stand-alone individual or group dental health
128 maintenance contract issued by a health maintenance organization organized under chapter
129 176G; or any oral surgical care, services, procedures or benefits covered by a stand-alone
130 individual or group preferred provider dental plan issued by a preferred provider arrangement
131 organized under chapter 176I; and stand-alone dental group health insurance plans issued by the
132 commission under chapter 32A.

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

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

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

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

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

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

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

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

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

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

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

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

194 Section 5. (a) The division of insurance, with the advice of the director of the connector,
195 shall issue regulations to define coverage for dental benefit plans and to implement this section.
196 The regulations shall include, but not be limited to, a determination of dental services eligible to
197 be defined under the following categories of services: (i) preventative and diagnostic; (ii) basic
198 restorative services; (iii) major restorative; and (iv) orthodontia. All carriers shall use this
199 definition.

200 (b) All dental benefit plans shall cover 100 per cent of preventative and diagnostic
201 services for those individuals aged 18 and older. All dental benefit plans shall cover 100 per cent
202 of preventative and diagnostic services and 100 per cent of basic restorative services for those
203 individuals under 18 years of age.

204 (c) No carrier shall issue, make effective, deliver or renew any dental benefit plan with a
205 contractual annual maximum limitation of benefit of less than \$1000 after April 1, 2016.

206 (d) All dental benefit plans shall allow a covered individual to carry over 100 per cent of
207 difference between the contractual annual maximum and actual benefits used from the current
208 calendar year to the next calendar year.

209 (e) No carrier shall issue, make effective, deliver or renew any dental benefit plan with a
210 contractual waiting limitation on preventative and diagnostic services.

211 (f) The division shall determine which, if any, dental services shall not be subject to a
212 contractual frequency limitation or other contractual limitation for certain individuals including,
213 but not limited to, individuals with diabetes, heart disease, and cancer.

214 Section 6. (a) The division of insurance shall issue regulations to define and review the
215 contracts between carriers and dentists and to implement this section.

216 (b) No contract between a carrier and a licensed dentist shall require that a dentist provide
217 dental services to subscribers or their covered dependents at a particular fee unless said dental
218 services are services for which the carrier provides payment. No new rule or regulation may be
219 promulgated by a party to the contract which would modify any reimbursed rate without the
220 consent of both parties to the contract.

221 (c) Carriers shall file any changes to reimbursement fee methodologies with the division
222 six months prior to the effective date of those changes. The commissioner shall disapprove any
223 reimbursement fee methodologies that do not increase reimbursements by at least the most recent
224 calendar year's percentage increase in the New England dental CPI. Rates of reimbursement or
225 rating factors included in the reimbursement methodology filing materials submitted for review
226 by the division shall be deemed confidential and exempt from the definition of public records in
227 clause Twenty-sixth of section 7 of chapter 4.

228 (d) The commissioner shall disapprove any reimbursement fee methodology that uses
229 geographic region for the purpose of area rate adjustment where the methodology: (i) uses 3 or
230 fewer geographic regions; (ii) the value of such an area rate adjustment is not within the range of
231 0.8 to 1.2; or (iii) public policy so dictates.

232 (e) Every carrier shall allow, as a provision in a group or individual policy, contract or
233 health plan for coverage of dental services, any person insured by such carrier to direct, in
234 writing, that benefits from a dental benefit plan be paid directly to a dentist who has not
235 contracted with the carrier to provide dental services to persons covered by the carrier but
236 otherwise meet the credentialing criteria of the entity and has not previously been terminated by
237 such entity as a participating provider. If written direction to pay is executed and written notice
238 of the direction is provided to such carrier, the carrier shall pay the benefits directly to the
239 dentist. The carrier paying the dentist, pursuant to a direction to pay duly executed by the
240 subscriber, shall have the right to review the records of the dentist receiving such payment that
241 relate exclusively to that particular subscriber/patient to determine that the service in question is
242 rendered. The paying carrier shall not pay the dentist who has not contracted with the carrier a
243 different rate than a dentist who has contracted with the carrier for the same services rendered.

244 (f) Fees for dental services paid to dentists shall be set in good faith and not be nominal.

245 SECTION 2. Notwithstanding any special or general law to the contrary, the division of
246 insurance, in consultation with the center for health information and analysis, shall promulgate
247 regulations on or before October 1, 2015 to establish a uniform methodology for calculating and
248 reporting by carriers for the medical loss ratios of dental benefit plans under section 2 of chapter
249 176V and section 6 of chapter 12C of the General Laws. The uniform methodology for
250 calculating and reporting medical loss ratios shall, at a minimum, specify a uniform method for
251 determining whether and to what extent an expenditure shall be considered a dental claims
252 expenditure or an administrative cost expenditure, which shall include, but not be limited to, a
253 determination of which of these classes of expenditures the following expenses fall into: (i)
254 financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses;

255 (iv) claims operations expenses; (v) dental administration expenses, such as disease
256 management, care management, utilization review and dental management activities; (vi)
257 network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees;
258 (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other
259 miscellaneous expenses not included in one of the previous categories. The methodology shall
260 conform with applicable federal statutes and regulations to the extent possible. The division
261 shall, before adopting regulations under this section, consult with: the group insurance
262 commission; the Centers for Medicare and Medicaid Services; the national association of
263 insurance commissioners; the attorney general; representatives from the Massachusetts
264 Association of Health Plans; the Massachusetts Dental Society; Health Care for All, Inc.; and a
265 representative from a small business association.