SENATE DOCKET, NO. 1291 FILED ON: 1/16/2015

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:
Harriette L. Chandler	*First Worcester*
John W. Scibak	*2nd Hampshire*
Ruth B. Balser	*12th Middlesex*
Diana DiZoglio	*14th Essex*
Sal N. DiDomenico	*Middlesex and Suffolk*

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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:

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

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

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

(f) 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 specific the scheduling of the hearings required under this section.

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

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

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

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

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

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

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

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

(c) Carriers shall file any changes to reimbursement fee methodologies with the division six months prior to the effective date of those changes. The commissioner shall disapprove any reimbursement fee methodologies that do not increase reimbursements by at least the most recent calendar year's percentage increase in the New England dental CPI. Rates of reimbursement or rating factors included in the reimbursement methodology 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.

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

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

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

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 October 1, 2015 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.