HOUSE . . . . No. 4378

The Commonwealth of Massachusetts

INITIATIVE PETITION OF MOUHAB RIZKALLAH AND OTHERS.

OFFICE OF THE SECRETARY.

BOSTON, JANUARY 28, 2022.

Steven T. James
Clerk of the House of Representatives
State House
Boston, Massachusetts 02133

Sir: — I herewith transmit to you, in accordance with the requirements of Article XLVIII of the Amendments to the Constitution an "Initiative Petition for a Law to Implement Medical Loss Ratios for Dental Benefit Plans." signed by ten qualified voters and filed with this department on or before December 1, 2021, together with additional signatures of qualified voters in the number of 104,212, being a sufficient number to comply with the Provisions of said Article.

Sincerely,

WILLIAM FRANCIS GALVIN
Secretary of the Commonwealth.

AN INITIATIVE PETITION.

Pursuant to Article XLVIII of the Amendments to the Constitution of the Commonwealth, as amended, the undersigned qualified voters of the Commonwealth, ten in number at least, hereby petition for the enactment into law of the following measure:

FILED ON: 2/2/2022

HOUSE . . . . No. 4378

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act to implement medical loss ratios for dental benefit plans.

Be it enacted by the People, and by their authority, as follows:

1 SECTION 1.

2 The General Laws are hereby amended by inserting after chapter 176W the following
3 chapter:-

4 Chapter 176X

5 Dental Benefit Plans

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

8 “Carrier”, an insurer or other entity offering dental benefit plans in the commonwealth.

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

10 “Connector”, the commonwealth health insurance connector, established by chapter
11 176Q.

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

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

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

30 “Third-party administrator”, a person or entity that, on behalf of a dental insurer or the
31 MassHealth dental program, or purchaser of dental benefits, provides administrative services
32 including receiving or collecting charges, contributions or premiums for, or adjusting or settling
33 claims on or for residents of the commonwealth.

34 Section 2. (a) Notwithstanding any general or special law to the contrary, the
35 commissioner may approve dental benefit policies submitted to the division of insurance for the
36 purpose of being provided to individuals and groups. These dental benefit policies shall be
37 subject to this chapter and may include networks that differ from those of a dental plan's overall
38 network. The commissioner shall adopt regulations regarding eligibility criteria.

39 (b) Notwithstanding any general or special law to the contrary, the commissioner shall
40 require carriers offering dental benefit plans to submit information as required by the
41 commissioner, which shall include the current and projected medical loss ratio for plans the
42 components of projected administrative expenses and financial information, including, but not
43 limited to: (i) underwriting, auditing, actuarial, financial analysis, treasury and investment
44 expenses; (ii) marketing and sales expenses, including but not limited to, advertising, member
45 relations, member enrollment and all expenses associated with producers, brokers and benefit
46 consultants; and (iii) claims operations expenses, including, but not limited to, adjudication,
47 appeals, settlements and expenses associated with paying claims. Unless otherwise determined
48 by the commissioner, the following items shall be deemed to be an administrative cost
49 expenditure for the purposes of calculating and reporting the medical loss ratio: (i) financial
50 administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses; (iv)
51 claims operations expenses; (v) medical administration expenses, such as disease management,
52 care management, utilization review and medical management activities; (vi) network operations
53 expenses; (vii) charitable expenses; (viii) board, bureau or association fees; (ix) state and federal
54 tax expenses, including assessments; and (x) payroll expense.

55 (c) Notwithstanding any general or special law to the contrary, carriers offering dental
56 benefit plans, including carriers licensed under chapters 175, 176B, 176E, 176G or 176I, shall

57 file group product base rates and any changes to group rating factors that are to be effective on
58 January 1 of each year, on or before July 1 of the preceding year. The commissioner shall
59 disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in
60 relation to the benefits charged. The commissioner shall disapprove any change to group rating
61 factors that is discriminatory or not actuarially sound. The commissioner shall adopt regulations
62 to carry out this section.

63 (d) If a carrier files a base rate change under this section and the administrative expense
64 loading component, not including taxes and assessments, increases by more than the most recent
65 calendar year's percentage increase in the dental services consumer price index (U.S. city
66 average, all urban consumers, not seasonally adjusted) or if a carrier's reported contribution to
67 surplus exceeds 1.9 per cent or if the aggregate medical loss ratio for all plans offered under this
68 chapter is less than the applicable percentage set forth in subsection (e), then such carrier's rate,
69 in addition to being subject to all other provisions of this chapter, shall be presumptively
70 disapproved as excessive by the commissioner as set forth in this subsection. If the annual
71 aggregate medical loss ratio for all plans offered under this chapter is less than the applicable
72 percentage set forth in subsection (e), the carrier shall refund the excess premium to its covered
73 individuals and covered groups. A carrier shall communicate within 30 days to all individuals
74 and groups that were covered under plans during the relevant 12-month period that such
75 individuals and groups qualify for a refund on the premium for the applicable 12-month period
76 or, if the individual or groups are still covered by the carrier, a credit on the premium for the
77 subsequent 12-month period. The total of all refunds issued shall equal the amount of a carrier's
78 earned premium that exceeds that amount necessary to achieve a medical loss ratio of the
79 applicable percentage set forth in subsection (e), calculated using data reported by the carrier as

80 prescribed under regulations promulgated by the commissioner. The commissioner may
81 authorize a waiver or adjustment of this requirement only if it is determined that issuing refunds
82 would result in financial impairment for the carrier.

83 (e) The medical loss ratio set forth in subsection (d) shall be 83 percent.

84 (f) If a proposed rate change has been presumptively disapproved: (i) a carrier shall
85 communicate to all employers and individuals covered under a group product that the proposed
86 increase has been presumptively disapproved and is subject to a hearing at the division of
87 insurance;

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

91 (iii) the attorney general may intervene in a public hearing or other proceeding under this
92 section and may require additional information as the attorney general considers necessary to
93 ensure compliance with this subsection. The commissioner shall adopt regulations to specify the
94 scheduling of the hearings required under this section and to otherwise carry out this subsection
95 (f).

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

102 the commissioner reverses the disapproval after a hearing or unless a court vacates the
103 commissioner's decision.

104 Section 3. (a) Each carrier shall submit an annual comprehensive financial statement to
105 the division detailing carrier costs from the previous calendar year. The annual comprehensive
106 financial statement shall include all of the information in this section and shall be itemized,
107 where applicable, by:

108 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25, and
109 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

110 (ii) line of business, including any stand-alone dental plan that covers oral surgical care,
111 dental services, dental procedures or benefits covered by any individual, general, blanket or
112 group policy of health, accident and sickness insurance issued by an insurer licensed or
113 otherwise authorized to transact accident and health insurance under chapter 175; any oral
114 surgical care, dental services, dental procedures or benefits covered by a stand-alone individual
115 or group dental medical service plan issued by a non-profit medical service corporation under
116 chapter 176B; any oral surgical care, dental services, dental procedures or benefits covered by a
117 stand-alone individual or group dental service plan issued by a dental service corporation
118 organized under chapter 176E; any oral surgical care, dental services, dental procedures or
119 benefits covered by a stand-alone individual or group dental health maintenance contract issued
120 by a health maintenance organization organized under chapter 176G; any oral surgical care,
121 dental services, dental procedures or benefits covered by a stand-alone individual or group
122 preferred provider dental plan issued by a preferred provider arrangement organized under

123 chapter 176I; and stand-alone dental group health insurance plans issued by the commission
124 under chapter 32A.

125 (b) The financial statement shall include, but shall not be limited to, the following
126 information: (i) direct premiums earned, as defined in chapter 176J; direct claims incurred, as
127 defined in said chapter 176J; (ii) medical loss ratio; (iii) number of members; (iv) number of
128 distinct groups covered; (v) number of lives covered; (vi) realized capital gains and losses; (vii)
129 net income; (viii) accumulated surplus; (ix) accumulated reserves; (x) risk-based capital ratio,
130 based on a formula developed by the National Association of Insurance Commissioners; (xi)
131 financial administration expenses, including underwriting, auditing, actuarial, financial analysis,
132 treasury and investment expenses; (xii) marketing and sales expenses, including advertising,
133 member relations, member enrollment expenses; (xiii) distribution expenses, including
134 commissions, producers, broker and benefit consultant expenses; (xiv) claims operations
135 expenses, including adjudication, appeals, settlements and expenses associated with paying
136 claims; (xv) dental administration expenses, including disease management, utilization review
137 and dental management expenses; (xvi) network operational expenses, including contracting,
138 dentist relations and dental policy procedures; (xvii) charitable expenses, including any
139 contributions to tax-exempt foundations and community benefits; (xviii) board, bureau or
140 association fees; (xix) any miscellaneous expenses described in detail by expense, including an
141 expense not included in (i) to (xviii), inclusive; (xx) payroll expenses and the number of
142 employees on the carrier's payroll; (xxi) taxes, if any, paid by the carrier to the federal
143 government or to the commonwealth; and (xxii) any other information deemed necessary by the
144 commissioner.

145 (c) Any carrier required to report under this section, which provides administrative
146 services to 1 or more self-insured groups shall include, as an appendix to such report, the
147 following information: (i) the number of the carrier's self-insured customers; (ii) the aggregate
148 number of members, as defined in section 1 of chapter 176J, in all of the carrier's self-insured
149 customers; (iii) the aggregate number of lives covered in all of the carrier's self-insured
150 customers; (iv) the aggregate value of direct premiums earned, as defined in said chapter 176J,
151 for all of the carrier's self-insured customers; (v) the aggregate medical loss ratio, as defined in
152 said chapter 176J, for all of the carrier's self-insured customers; (vi) net income; (vii)
153 accumulated surplus; (viii) accumulated reserves; (ix) the percentage of the carrier's self-insured
154 customers that include each of the benefits mandated for health benefit plans under chapters 175,
155 176A, 176B and 176G; (x) administrative service fees paid by each of the carrier's self-insured
156 customers; and (xi) any other information deemed necessary by the commissioner.

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

165 The commissioner shall adopt rules to carry out this subsection, including standards and
166 procedures requiring the registration of persons or entities not otherwise licensed or registered by
167 the commissioner, such as third-party administrators, and criteria for the standardized reporting

168 and uniform allocation methodologies among carriers. The division shall, before adopting
169 regulations under this section, consult with other agencies of the commonwealth and the federal
170 government and affected carriers to ensure that the reporting requirements imposed under the
171 regulations are not duplicative.

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

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

185 Section 4. Except as otherwise provided below, this chapter shall apply to all dental
186 benefit plans, including plans issued directly by a carrier, through the connector, or through an
187 intermediary. This chapter shall not apply to dental benefit plans issued, delivered or renewed to
188 a self-insured group or where the carrier is acting as a third-party administrator. Nothing in this

189 chapter shall be construed to require a carrier that does not issue dental benefit plans subject to

190 this chapter to issue dental benefit plans subject to this chapter.

191 SECTION 2.

192 Section 10 of chapter 12C of the General Laws is hereby amended by inserting at the end

193 of clause (4) of subsection (b):—

194 "or section 3 of chapter 176X".

195 SECTION 3.

196 The commissioner of insurance shall promulgate by October 1, 2023, regulations

197 consistent with this act.

198 SECTION 4.

199 Except as otherwise provided herein, this act shall apply to all dental benefit plans issued,

200 made effective, delivered or renewed on or after January 1, 2024.

FIRST TEN SIGNERS

NAME	RESIDENCE	CITY OR TOWN
Mouhab Rizkallah	34 Arlington Street	Winchester
Robert N. Petrosino	43 Eliot Road	Needham
Andrew Seth Chase	131 Clapboardtree Street	Westwood
Patricia L. Brown	50 Hereford Street	Boston
Laura H. Rizkallah	34 Arlington Street	Winchester
Linda J. Gendall	11 Harrison Street	Stoneham
John S. Gendall	11 Harrison Street	Stoneham
Joanne M. Dempsey-Lowe	252 Massachusetts Avenue #6	Arlington
Neill Kumar	50 Hillsdale Road	Medford
Dayse E.P. Kumar	38 Capen Street	Medford

CERTIFICATE OF THE ATTORNEY GENERAL.

September 1, 2021.

Honorable William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Room 1705
Boston, Massachusetts 02108

Re: Initiative Petition No. 21-13: Initiative Petition for a Law to Implement Medical Loss Ratios for Dental Benefit Plans

Dear Secretary Galvin:

In accordance with the provisions of Article 48 of the Amendments to the Massachusetts Constitution, I have reviewed the above-referenced initiative petition, which was submitted to me on or before the first Wednesday of August of this year.

I hereby certify that this measure is in proper form for submission to the people; that the measure is not, either affirmatively or negatively, substantially the same as any measure which has been qualified for submission or submitted to the people at either of the two preceding biennial state elections; and that it contains only subjects that are related or are mutually dependent and which are not excluded from the initiative process pursuant to Article 48, the Initiative, Part 2, Section 2.

In accordance with Article 48, I enclose a fair, concise summary of the measure.

Sincerely,

MAURA HEALEY,
Attorney General.

Summary of 21-13.

This proposed law would direct the Commissioner of the Massachusetts Division of Insurance to approve or disapprove the rates of dental benefit plans and would require that a dental insurance carrier meet an annual aggregate medical loss ratio for its covered dental benefit plans of 83 percent. The medical loss ratio would measure the amount of premium dollars a dental insurance carrier spends on its members' dental expenses and quality improvements, as opposed to administrative expenses. If a carrier's annual aggregate medical loss ratio is less than 83 percent, the carrier would be required to refund the excess premiums to its covered individuals and groups. The proposed law would allow the Commissioner to waive or adjust the refunds only if it is determined that issuing refunds would result in financial impairment for the carrier.

The proposed law would apply to dental benefit plans regardless of whether they are issued directly by a carrier, through the connector, or through an intermediary. The proposed law would not apply to dental benefit plans issued, delivered, or renewed to a self-insured group or where the carrier is acting as a third-party administrator.

The proposed law would require the carriers offering dental benefit plans to submit information about their current and projected medical loss ratio, administrative expenses, and other financial information to the Commissioner. Each carrier would be required to submit an annual comprehensive financial statement to the Division of Insurance, itemized by market group size and line of business. A carrier that also provides administrative services to one or more self-insured groups would also be required to file an appendix to their annual financial

statement with information about its self-insured business. The proposed law would impose a late penalty on a carrier that does not file its annual report on or before April 1.

The Division would be required to make the submitted data public, to issue an annual summary to certain legislative committees, and to exchange the data with the Health Policy Commission. The Commissioner would be required to adopt standards requiring the registration of persons or entities not otherwise licensed or registered by the Commissioner and criteria for the standardized reporting and uniform allocation methodologies among carriers.

The proposed law would allow the Commissioner to approve dental benefit policies for the purpose of being offered to individuals or groups. The Commissioner would be required to adopt regulations to determine eligibility criteria.

The proposed law would require carriers to 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 would be required to disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in relation to the benefits charged. The Commissioner would also be required to disapprove any change to group rating factors that is discriminatory or not actuarially sound.

The proposed law sets forth criteria that, if met, would require the Commissioner to presumptively disapprove a carrier's rate, including if the aggregate medical loss ratio for all dental benefit plans offered by a carrier is less than 83 percent.

The proposed law would establish procedures to be followed if a proposed rate is presumptively disapproved or if the Commissioner disapproves a rate.

The proposed law would require the Division to hold a hearing if a carrier reports a risk-based capital ratio on a combined entity basis that exceeds 700 percent in its annual report.

The proposed law would require the Commissioner to promulgate regulations consistent with its provisions by October 1, 2023. The proposed law would apply to all dental benefit plans issued, made effective, delivered, or renewed on or after January 1, 2024.