

SENATE No. 632

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 medical loss ratio reporting for dental benefits corporations.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>Harriette L. Chandler</i>	<i>First Worcester</i>	
<i>Joanne M. Comerford</i>	<i>Hampshire, Franklin and Worcester</i>	<i>4/15/2021</i>

SENATE No. 632

By Ms. Chandler, a petition (accompanied by bill, Senate, No. 632) of Harriette L. Chandler for legislation relative to financial services contracts for dental benefits corporations. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. 545 OF 2019-2020.]

The Commonwealth of Massachusetts

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

An Act relative to medical loss ratio reporting for dental benefits corporations.

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

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

3 Chapter 176V

4 Dental Benefit Plans

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

7 “Carrier”, any insurer licensed or otherwise authorized to transact accident and health
8 insurance under chapter 175, non-profit medical service corporation under chapter 176B; a
9 dental service corporation organized under chapter 176E, health maintenance organization

10 organized under chapter 176G, or preferred provider arrangement organized under chapter 176I
11 offering dental benefit plans in the commonwealth.

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

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

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

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

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

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

34 Section 2. Except as otherwise provided, this chapter applies to all dental benefit plans
35 issued, made effective, delivered or renewed after April 1, 2021 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 Section 4. (a) Each carrier shall submit an annual comprehensive financial statement to
62 the division detailing carrier costs from the previous calendar year. The annual comprehensive
63 financial statement shall include all of the information in this section and shall be itemized,
64 where applicable, by:

65 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25, and
66 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

67 (ii) line of business, including any stand-alone dental plan that covers oral surgical care,
68 services, procedures or benefits covered by any individual, general, blanket or group policy of
69 health, accident and sickness insurance issued by an insurer licensed or otherwise authorized to
70 transact accident and health insurance under chapter 175; any oral surgical care, services,
71 procedures or benefits covered by a stand-alone individual or group dental medical service plan
72 issued by a non-profit medical service corporation under chapter 176B; any oral surgical care,
73 services, procedures or benefits covered by a stand-alone individual or group dental service plan

74 issued by a dental service corporation organized under chapter 176E; any oral surgical care,
75 services, procedures or benefits covered by a stand-alone individual or group dental health
76 maintenance contract issued by a health maintenance organization organized under chapter
77 176G; or any oral surgical care, services, procedures or benefits covered by a stand-alone
78 individual or group preferred provider dental plan issued by a preferred provider arrangement
79 organized under chapter 176I; and stand-alone dental group health insurance plans issued by the
80 commission under chapter 32A.

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

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

84 (iv) number of distinct groups covered; (v) number of lives covered; (vi) realized capital
85 gains and losses; (viii) net income; (ix) accumulated surplus; (x) accumulated reserves; (xi) risk-
86 based capital ratio, based on a formula developed by the National Association of Insurance
87 Commissioners; (xii) financial administration expenses, including underwriting, auditing,
88 actuarial, financial analysis, treasury and investment purposes; (xiii) marketing and sales
89 expenses, including advertising, member relations, member enrollment expenses; (xiv)
90 distribution expenses, including commissions, producers, broker and benefit consultant expenses;
91 (xv) claims operations expenses, including adjudication, appeals, settlements and expenses
92 associated with paying claims; (xvi) dental administration expenses, including disease
93 management, utilization review and dental management expenses; (xvii) network operational
94 expenses, including contracting, dentist relations and dental policy procedures; (xviii) charitable

95 expenses, including any contributions to tax-exempt foundations and community benefits; (xix)
96 board, bureau or association fees;

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

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

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

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

114 (c) A carrier who fails to file this report on or before April 1 shall be assessed a late
115 penalty not to exceed \$100 per day. The division shall make public all of the information
116 collected under this section. The division shall issue an annual summary report to the joint

117 committee on financial services, the joint committee on health care financing and the house and
118 senate committees on ways and means of the annual comprehensive financial statements by May
119 15. The information shall be exchanged with the center for health information and analysis for
120 use under section 10 of chapter 12C. The division shall, from time to time, require payers to
121 submit the underlying data used in their calculations for audit.

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

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

137 (e) The commissioner may waive specific reporting requirements in this section for
138 classes of carriers for which the commissioner deems such reporting requirements to be

139 inapplicable; provided, however, that the commissioner shall provide written notice of any such
140 waiver to the joint committee on health care financing and the house and senate committees on
141 ways and means.

142 SECTION 2. Notwithstanding any special or general law to the contrary, the division of
143 insurance, in consultation with the center for health information and analysis, shall promulgate
144 regulations on or before January 1, 2019 to establish a uniform methodology for calculating and
145 reporting by carriers for the medical loss ratios of dental benefit plans under section 2 of chapter
146 176V and section 6 of chapter 12C of the General Laws. The uniform methodology for
147 calculating and reporting medical loss ratios shall, at a minimum, specify a uniform method for
148 determining whether and to what extent an expenditure shall be considered a dental claims
149 expenditure or an administrative cost expenditure, which shall include, but not be limited to, a
150 determination of which of these classes of expenditures the following expenses fall into: (i)
151 financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses;
152 (iv) claims operations expenses; (v) dental administration expenses, such as disease
153 management, care management, utilization review and dental management activities; (vi)
154 network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees;
155 (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other
156 miscellaneous expenses not included in one of the previous categories. The methodology shall
157 conform with applicable federal statutes and regulations to the extent possible. The division
158 shall, before adopting regulations under this section, consult with: the group insurance
159 commission; the Centers for Medicare and Medicaid Services; the national association of
160 insurance commissioners; the attorney general; representatives from the Massachusetts

161 Association of Health Plans; the Massachusetts Dental Society; Health Care for All, Inc.; and a
162 representative from a small business association.