SENATE DOCKET, NO. 1627 FILED ON: 1/16/2025

SENATE . . . . . No. 696

The Commonwealth of Massachusetts

PRESENTED BY:

Brendan P. Crighton

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 ensuring transparency in the practice of dental leased networks.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Brendan P. Crighton	*Third Essex*

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SENATE . . . . . No. 696

By Mr. Crighton, a petition (accompanied by bill, Senate, No. 696) of Brendan P. Crighton for legislation to ensure transparency in the practice of dental leased networks. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act ensuring transparency in the practice of dental leased networks.

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

The General Laws are hereby amended by inserting after Chapter 176X the following new chapter:-

Chapter 176Y

Section 1. For the purpose of Chapter 176Y, the following words shall have the following meanings:

"Provider Network Entity" means any person or entity, including a Carrier, that: (i) contracts with Participating Dental Providers and has a direct written agreement with such Participating Dental Providers for the delivery of healthcare services or benefits; or (ii) sells, rents, leases, or grants access to Dental Networks to Third-party Health Plans.

"Third-party Health Plan" means any person or entity, including a Carrier, that enters into a contract with a Provider Network Entity to gain access to the Provider Network Entity's network of Participating Dental Providers whereby the cost of dental services furnished to

subscribers and covered dependents are paid pursuant to the Third-party Health Plan's own Dental Benefit Plan.

"Commissioner" means The Commissioner of Insurance.

"Carrier" means an insurer or other entity offering dental benefit plans in the Commonwealth.

"Participating Dental Provider" means a registered dentist, under an express written agreement with a Provider Network Entity, has agreed to perform Dental Service to subscribers and covered dependents, and to abide by the by-laws, rules and regulations of such Provider Network Entity, with an expectation of receiving payment, other than coinsurance, copayments or deductibles. For the purpose of Chapter 176Y, any notices or disclosures that Provider Network Entity and/or Third-party Health Plan are required to send to the Participating Dental Provider shall be addressed to the contracting party as specified in the written agreement between Participating Dental Provider and the Provider Network Entity.

"Dental Service" means the dental services ordinarily provided by registered dentists and dental practices in accordance with accepted practices in the community where the services are rendered.

"Dental Benefit Plan" means any dental plan that covers oral surgical care, dental services, dental 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, dental services, dental 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, dental services, dental procedures or benefits covered by a stand-alone individual or group dental service plan issued by a dental service corporation under chapter 176E; any oral surgical care, dental services, dental 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, dental services, dental 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. The commissioner may, by regulation, define other dental coverage as a qualifying dental benefit plan for the purposes of this Section.

“Dental Network” means an arrangement of Participating Dental Providers, created and/or maintained by Provider Network Entity who have agreed to certain reimbursement for Dental Services provided to subscribers or their dependents.

"Registered dentist" means a dentist registered to practice dentistry in the commonwealth as provided in sections 45 and 48 of chapter 112 or a dentist registered in any other jurisdiction within the United States and its territories.

Section 2. Contractual Arrangement Transparency.

a. Notwithstanding any general or special law to the contrary, any Provider Network Entity that sells, rents, leases or grants access to its Participating Dental Providers or its Dental Network, directly or indirectly, to Third-Party Health Plans shall (i) have a signed written agreement with each Participating Dental Provider who participates in any of the Provider Network Entity’s Dental Networks and (ii) comply with the requirements of this Section.

b. At the time of initial contracting, the Provider Network Entity shall provide each Participating Dental Provider with (i) a list of the Third-Party Health Plans to which the Provider Network Entity has leased, rented or otherwise made it Dental Network accessible, and that the dentist will now be considered in-network for the Third-Party Health Plan's Dental Network (ii) if signed agreement between Provider Network Entity and Participating Dental Provider includes multiple fee schedules, Provider Network Entity shall identify which fee schedule will be utilized by each Third-Party Health, (iii) applicable Third-party Health Plan's credentialing practices and administrative policy and procedures; and (iv) any other material terms affecting the Participating Dental Provider's participation in the Third-Party Provider Network Entity's Dental Networks.

c. Third-party Health Plans shall reimburse Participating Dental Providers in accordance with the contracted fee schedule for the respective Dental Benefit Plan indicated in section 2(b)(ii). In the event the Third-Party Health Plan utilizes more than one Dental Network which could be a combination of proprietary and/or multiple Provider Network Entities Third-Party Health Plan shall provide written notice to each Participating Dental Provider identifying the specific Provider Network Entity contract being accessed for that Dental Benefit Plan and the notice must specify the applicable fee schedule that will be used for reimbursement for that specific Dental Benefit Plan. Third-party Health Plan shall also provide written notice to Participating Dental Provider identifying the specific Provider Network Entity and/or the prevailing fee schedule in advance to making any changes or updates.

d. In the event of a proposed change or amendment in the written agreement between the Provider Network entity and Participating Dental Provider, the Provider Network Entity shall reissue the notice requirements in section 2(b).

Section 3. Notification of Access to Provider Network

a. Each Third-party Health Plan shall, in clear and conspicuous language, notify its insured and administrative services only customers that the Third-party Health Plan is renting, leasing or otherwise making accessible, a network of providers from a Provider Network Entity. Annually, the Third-party Health Plan shall provide a report to its insured and administrative services only customers, including a total number of subscribers and their dependents that received Dental Services from each Provider Network entity. Third-party Health Plan is required to adopt and/or maintain consistent credentialing standards, utilization review and management processes, and quality of care practice or protocols (collectively, "Provider Quality Measures") for all Dental Networks to which the Third-party Health Plan provides access, regardless of whether such Dental Networks are proprietary and internal to the operations of the Third-party Health Plan or through a Provider Network Entity. If the Third-party Health Plan does not adopt and maintain consistent Provider Quality Measures, the Third-party Health Plan shall notify its insured and administrative services only customers annually that it does not maintain consistent Provider Quality Measures and the differences in such Provider Quality Measures used for the Dental Networks.

b. Each Third-party Health Plan's provider directory shall indicate the listed providers are part of a leased, rented or made otherwise accessible, through a contractual arrangement with the Provider Network Entity and that Third-party Health Plan does not have a direct contract with such Participating Dental Provider. Each Third-party Health Plan shall notify its subscribers and their dependents annually that any disputes or disagreement that arise between a subscriber or their dependents and the Participating Dental Provider shall be resolved according to the terms of

the direct written agreement between the Participating Dental Provider and the Provider Network Entity.

c. Annually, but no later than Nov 15, each Provider Network Entity shall provide each Participating Dental Provider the notice requirements in section 2(b). The notice shall include, in addition to the list of Third-party Health Plans that utilize the Participating Dental Provider, the volume of patients seen through each Third-party Health Plan.

Section 4. Commissioner's approval.

Third-Party Health Plan that is renting, leasing or otherwise accessing a Dental Network under this Section shall at all times be subject to a public hearing as provided by section two of chapter 30A and receive prior written approval from the Commissioner. No such arrangement shall be approved if the Commissioner finds the use of such Dental Network by a Dental Benefit Plan or by the Third-Party Health Plan is unreasonable in relation to (i) the median fee schedule reimbursement from all Dental Benefit Plans offering by Carriers, (ii) the premium charged for such services, and (iii) if the premium charge are excessive, inadequate or unfairly discriminatory.