JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY

Bill No: H1262

Title: AN ACT RELATIVE TO DENTAL INSURANCE

Sponsor: Rep. Paul McMurtry (*Dedham)*

Hearing Date: October 27, 2025

Reporting Deadline: December 3, 2025

Prior History: None

Similar Matters: S676 (Brady – Identical)

CURRENT LAW:
MG.L. c. 176X Dental Benefit Plans §2
Approval of dental benefit policies; information to be submitted to the commissioner; group product base rates; medical loss ratio; disapproval of proposed rate change

(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 dental services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted) 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 the commissioner will presumptively disapprove as excessive the carrier's rate as set forth in this subsection.

§3 Annual comprehensive financial statement; contents; appendix; failure to file; public hearing for excessive risk-based capital ratio; waivers

(a) Each carrier will submit an annual comprehensive financial statement to the division detailing carrier costs from the previous calendar year. The annual comprehensive financial statement will include all the information in this section and will 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

(c) Any carrier required to report under this section, which provides administrative services to 1 or more self-insured groups will 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; (v) the aggregate medical loss ratio, as defined in said chapter 176J, for all of the carrier's self-insured customers; (vi) net income; (vii) accumulated surplus; (viii)

accumulated reserves; (ix) 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; (x) administrative service fees paid by each of the carrier's self-insured customers; and (xi) any other information deemed necessary by the commissioner.

(e) If, in any year, a carrier reports a risk-based capital (RBC) ratio on a combined entity basis under subsection (a) that exceeds 700 percent, the division of insurance will hold a public hearing within 60 days. The carrier will submit testimony on its overall financial condition and the continued need for additional surplus. The carrier will 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 will review the testimony and will issue a final report on the results of the hearing.

(f) 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 will 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.

211 CMR 20 Risk-Based Capital (RBC) for insurers

211 CMR 20.01: Definitions
Company Action Level RBC. With respect to any insurer, the product of 2.0 and its Authorized Control Level RBC

211 CMR 25 Risk-Based Capital (RBC) for health organizations

SUMMARY:
SECTION 1.
Changes the law to allow a dental carrier to report a surplus contribution more than 1.9 percent, without triggering the insurance commissioner’s automatic rate disapproval on that basis.

SECTION 2.
Simplifies the group reporting structure dental carriers must submit to the insurance commissioner on their annual comprehensive financial statement to small groups of 2-50; and large groups of greater than 50.

SECTION 3.
Eliminates reporting requirements for third party administrators.

SECTION 4.
Adds language to the law designating that life insurers will apply the risk-based capital (RBC) model according to *211 CMR 20.00*. Whereas life and other multi-line carriers that have most of their liabilities in non-dental or non-Massachusetts insurance lines that will not exceed 700% of their respective Company Action Level (CAL), as defined in *211 CMR 20.00*. Designates that Massachusetts-based health and dental-only carriers will apply the RBC model according to *211 CMR 25*.

SECTION 5.
Changes the law to allow the insurance commissioner to waive specific reporting requirements, not for those for whom he designates the requirements inapplicable, but rather for those unable to provide the required information.