HOUSE DOCKET, NO. 1599 FILED ON: 1/19/2017

HOUSE . . . . . No. 582

The Commonwealth of Massachusetts

PRESENTED BY:

John W. Scibak

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:
John W. Scibak	*2nd Hampshire*
Harriette L. Chandler	*First Worcester*
Angelo J. Puppolo, Jr.	*12th Hampden*
David Paul Linsky	*5th Middlesex*
Kenneth I. Gordon	*21st Middlesex*
Bradford R. Hill	*4th Essex*
Barbara A. L'Italien	*Second Essex and Middlesex*
Jennifer E. Benson	*37th Middlesex*
Chris Walsh	*6th Middlesex*
Kathleen O'Connor Ives	*First Essex*
Michael J. Barrett	*Third Middlesex*
Paul K. Frost	*7th Worcester*
Kay Khan	*11th Middlesex*
Thomas J. Calter	*12th Plymouth*
James M. Cantwell	*4th Plymouth*
John H. Rogers	*12th Norfolk*
Sean Garballey	*23rd Middlesex*

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HOUSE . . . . . No. 582

By Mr. Scibak of South Hadley, a petition (accompanied by bill, House, No. 582) of John W. Scibak and others relative to dental insurance benefit plans and further protecting the rights of dental patients. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

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, 2017 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.

Section 4. (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, 2018.

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

(b) 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.

(c) 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.

(d) 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.

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