

HOUSE No. 584

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 medical loss ratio for insurance corporations.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>John W. Scibak</i>	<i>2nd Hampshire</i>
<i>Harriette L. Chandler</i>	<i>First Worcester</i>
<i>David Paul Linsky</i>	<i>5th Middlesex</i>
<i>Kenneth I. Gordon</i>	<i>21st Middlesex</i>
<i>Bradford R. Hill</i>	<i>4th Essex</i>
<i>James M. Cantwell</i>	<i>4th Plymouth</i>
<i>Barbara A. L'Italien</i>	<i>Second Essex and Middlesex</i>
<i>Kathleen O'Connor Ives</i>	<i>First Essex</i>
<i>Michael J. Barrett</i>	<i>Third Middlesex</i>
<i>Paul K. Frost</i>	<i>7th Worcester</i>
<i>Thomas J. Calter</i>	<i>12th Plymouth</i>
<i>Sean Garballey</i>	<i>23rd Middlesex</i>

HOUSE No. 584

By Mr. Scibak of South Hadley, a petition (accompanied by bill, House, No. 584) of John W. Scibak and others relative to medical loss ratio for insurance corporations and dental benefit plans. Financial Services.

The Commonwealth of Massachusetts

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

An Act relative to medical loss ratio for insurance 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, 2017 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 (c) Notwithstanding any general or special law to the contrary, carriers offering dental
62 benefit plans, including carriers licensed under chapters 175, 176B, 176E, 176G or 176I, shall
63 file group product base rates and any changes to group rating factors that are to be effective on
64 January 1 of each year, on or before July 1 of the preceding year. The commissioner shall
65 disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in
66 relation to the benefits charged. The commissioner shall disapprove any change to group rating
67 factors that is discriminatory or not actuarially sound. Rates of reimbursement or rating factors
68 included in the rate filing materials submitted for review by the division shall be deemed
69 confidential and exempt from the definition of public records in clause Twenty-sixth of section 7
70 of chapter 4. The commissioner shall adopt regulations to carry out this section.

71 (d) If a carrier files a base rate change under this section and the administrative expense
72 loading component, not including taxes and assessments, increases by more than the most recent
73 calendar year's percentage increase in the New England dental CPI or if a carrier's reported
74 contribution to surplus exceeds 1.9 percent or if the aggregate medical loss ratio for all plans
75 offered under this chapter is less than the applicable percentage set forth in subsection (e), then
76 such carrier's rate, in addition to being subject to all other provisions of this chapter, shall be
77 presumptively disapproved as excessive by the commissioner as set forth in this subsection.

78 If the annual aggregate medical loss ratio for all plans offered under this chapter is less
79 than the applicable percentage set forth in subsection (e) the carrier shall refund the excess
80 premium to its covered individuals and covered groups. A carrier shall communicate within 30
81 days to all individuals and groups that were covered under plans during the relevant 12-month
82 period that such individuals and groups qualify for a refund on the premium for the applicable
83 12-month period or, if the individual or groups are still covered by the carrier, a credit on the
84 premium for the subsequent 12-month period. The total of all refunds issued shall equal the
85 amount of a carrier's earned premium that exceeds the amount necessary to achieve a medical
86 loss ratio of the applicable percentage set forth in subsection (e), calculated using data reported
87 by the carrier as prescribed under regulations promulgated by the commissioner. The
88 commissioner may authorize a waiver or adjustment of this requirement only if it is determined
89 that issuing refunds would result in a significant financial impairment for the carrier.

90 (e) The medical loss ratio set forth in subsection (d) shall be 80 percent for the period
91 from January 1, 2019 forward.

92 (f) If a proposed rate change has been presumptively disapproved:

93 (i) a carrier shall communicate to all employers and individuals covered under a group
94 product that the proposed increase has been presumptively disapproved and is subject to a
95 hearing at the division of insurance;

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

99 (iii) the attorney general may intervene in a public hearing or other proceeding under this
100 section and may require additional information as the attorney general considers necessary to
101 ensure compliance with this subsection.

102 The commissioner shall adopt regulations to specify the scheduling of the hearings
103 required under this section.

104 (h) If the commissioner disapproves the rate submitted by a carrier the commissioner
105 shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the
106 carrier's rate. The carrier may submit a request for hearing to the division of insurance within 10
107 days of such notice of disapproval. The division must schedule a hearing within 15 days of
108 receipt. The commissioner shall issue a written decision within 30 days after the conclusion of
109 the hearing. The carrier may not implement the disapproved rates, or changes at any time unless
110 the commissioner reverses the disapproval after a hearing or unless a court vacates the
111 commissioner's decision.

112 Section 4. (a) Each carrier shall submit an annual comprehensive financial statement to
113 the division detailing carrier costs from the previous calendar year. The annual comprehensive
114 financial statement shall include all of the information in this section and shall be itemized,
115 where applicable, by:

116 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25, and
117 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

118 (ii) line of business, including any stand-alone dental plan that covers oral surgical care,
119 services, procedures or benefits covered by any individual, general, blanket or group policy of
120 health, accident and sickness insurance issued by an insurer licensed or otherwise authorized to

121 transact accident and health insurance under chapter 175; any oral surgical care, services,
122 procedures or benefits covered by a stand-alone individual or group dental medical service plan
123 issued by a non-profit medical service corporation under chapter 176B; any oral surgical care,
124 services, procedures or benefits covered by a stand-alone individual or group dental service plan
125 issued by a dental service corporation organized under chapter 176E; any oral surgical care,
126 services, procedures or benefits covered by a stand-alone individual or group dental health
127 maintenance contract issued by a health maintenance organization organized under chapter
128 176G; or any oral surgical care, services, procedures or benefits covered by a stand-alone
129 individual or group preferred provider dental plan issued by a preferred provider arrangement
130 organized under chapter 176I; and stand-alone dental group health insurance plans issued by the
131 commission under chapter 32A.

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

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

135 (iv) number of distinct groups covered; (v) number of lives covered; (vii) realized capital
136 gains and losses; (viii) net income; (ix) accumulated surplus; (x) accumulated reserves; (xi) risk-
137 based capital ratio, based on a formula developed by the National Association of Insurance
138 Commissioners; (xii) financial administration expenses, including underwriting, auditing,
139 actuarial, financial analysis, treasury and investment purposes; (xiii) marketing and sales
140 expenses, including advertising, member relations, member enrollment expenses; (xiv)
141 distribution expenses, including commissions, producers, broker and benefit consultant expenses;
142 (xv) claims operations expenses, including adjudication, appeals, settlements and expenses

143 associated with paying claims; (xvi) dental administration expenses, including disease
144 management, utilization review and dental management expenses; (xvii) network operational
145 expenses, including contracting, dentist relations and dental policy procedures; (xviii) charitable
146 expenses, including any contributions to tax-exempt foundations and community benefits; (xix)
147 board, bureau or association fees;

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

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

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

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

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

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

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

188 (e) The commissioner may waive specific reporting requirements in this section for
189 classes of carriers for which the commissioner deems such reporting requirements to be
190 inapplicable; provided, however, that the commissioner shall provide written notice of any such
191 waiver to the joint committee on health care financing and the house and senate committees on
192 ways and means.

193 SECTION 2. Notwithstanding any special or general law to the contrary, the division of
194 insurance, in consultation with the center for health information and analysis, shall promulgate
195 regulations on or before January 1, 2019 to establish a uniform methodology for calculating and
196 reporting by carriers for the medical loss ratios of dental benefit plans under section 2 of chapter
197 176V and section 6 of chapter 12C of the General Laws. The uniform methodology for
198 calculating and reporting medical loss ratios shall, at a minimum, specify a uniform method for
199 determining whether and to what extent an expenditure shall be considered a dental claims
200 expenditure or an administrative cost expenditure, which shall include, but not be limited to, a
201 determination of which of these classes of expenditures the following expenses fall into: (i)
202 financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses;
203 (iv) claims operations expenses; (v) dental administration expenses, such as disease
204 management, care management, utilization review and dental management activities; (vi)
205 network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees;
206 (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other
207 miscellaneous expenses not included in one of the previous categories. The methodology shall
208 conform with applicable federal statutes and regulations to the extent possible. The division
209 shall, before adopting regulations under this section, consult with: the group insurance
210 commission; the Centers for Medicare and Medicaid Services; the national association of

211 insurance commissioners; the attorney general; representatives from the Massachusetts
212 Association of Health Plans; the Massachusetts Dental Society; Health Care for All, Inc.; and a
213 representative from a small business association.