SUMMARY OF NO. 21-13

This proposed law would direct the Commissioner of the Massachusetts Division of Insurance to approve or disapprove the rates of dental benefit plans and would require that a dental insurance carrier meet an annual aggregate medical loss ratio for its covered dental benefit plans of 83 percent. The medical loss ratio would measure the amount of premium dollars a dental insurance carrier spends on its members' dental expenses and quality improvements, as opposed to administrative expenses. If a carrier's annual aggregate medical loss ratio is less than 83 percent, the carrier would be required to refund the excess premiums to its covered individuals and groups. The proposed law would allow the Commissioner to waive or adjust the refunds only if it is determined that issuing refunds would result in financial impairment for the carrier.

The proposed law would apply to dental benefit plans regardless of whether they are issued directly by a carrier, through the connector, or through an intermediary. The proposed law would not apply to dental benefit plans issued, delivered, or renewed to a self-insured group or where the carrier is acting as a third-party administrator.

The proposed law would require the carriers offering dental benefit plans to submit information about their current and projected medical loss ratio, administrative expenses, and other

financial information to the Commissioner. Each carrier would be required to submit an annual comprehensive financial statement to the Division of Insurance, itemized by market group size and line of business. A carrier that also provides administrative services to one or more self-insured groups would also be required to file an appendix to their annual financial statement with information about its self-insured business. The proposed law would impose a late penalty on a carrier that does not file its annual report on or before April 1.

The Division would be required to make the submitted data public, to issue an annual summary to certain legislative committees, and to exchange the data with the Health Policy Commission. The Commissioner would be required to adopt standards requiring the registration of persons or entities not otherwise licensed or registered by the Commissioner and criteria for the standardized reporting and uniform allocation methodologies among carriers.

The proposed law would allow the Commissioner to approve dental benefit policies for the purpose of being offered to individuals or groups. The Commissioner would be required to adopt regulations to determine eligibility criteria.

The proposed law would require carriers to file group product base rates and any changes to group rating factors that are to be effective on January 1 of each year on or before July

1 of the preceding year. The Commissioner would be required to disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in relation to the benefits charged. The Commissioner would also be required to disapprove any change to group rating factors that is discriminatory or not actuarially sound.

The proposed law sets forth criteria that, if met, would require the Commissioner to presumptively disapprove a carrier's rate, including if the aggregate medical loss ratio for all dental benefit plans offered by a carrier is less than 83 percent.

The proposed law would establish procedures to be followed if a proposed rate is presumptively disapproved or if the Commissioner disapproves a rate.

The proposed law would require the Division to hold a hearing if a carrier reports a risk-based capital ratio on a combined entity basis that exceeds 700 percent in its annual report.

The proposed law would require the Commissioner to promulgate regulations consistent with its provisions by October 1, 2023. The proposed law would apply to all dental benefit plans issued, made effective, delivered, or renewed on or after January 1, 2024.