Chapter 287 of the Acts of 2022

Information Session #4 on Wednesday, March 1 at 1PM – Reporting

Section of 1 of Chapter 287 creates Chapter 176X. Section 3 describes the information to be reported.

Section 3.(a)

"Each carrier shall submit an annual comprehensive financial statement to the division detailing carrier costs from the previous year. The annual comprehensive financial statement shall include all of the information in this section and shall 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

(ii) line of business, including any stand-alone 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 insured 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 services corporation under chapter 176B; any oral surgical care, dental services, dental procedures or benefits covered by a stand-alone individual or group dental services issued by a dental service corporation organized 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; and 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; and stand-alone dental group health insurance plans issued by the commission under chapter 32A."

1) Is it clear that that the reporting requirements apply to all markets in which a dental carrier issues coverage in Massachusetts? Is it clear that the reporting requirements are not intended to include any information for coverage issued in any jurisdiction outside Massachusetts?

2) Regarding reporting by group size, are all the reporting categories clear? Should the reporting group size be based on the number of subscribers eligible within a group or the number active in a group? Should the group size be counted regardless of the state in which the members of the group live?

3) How should group associations/trusts fit in the group size categories? Should they be reported according to the number of members in the group who are eligible for dental coverage? Should they reported according to the size of the eligible pool in Massachusetts or the eligible pool nationally?

4) Is it clear how carriers should report separate statistics for lines of business? Should information be reported separately for open network, preferred network and closed network products? Should information be reported separately for Medicare and Medicaid products? Since it is noted that information is to be reported for stand-alone dental plans issued by the Group Insurance Commission (chapter 32A), should these plans be reported separately as a separate line of business?

5) Is it clear that carriers should report separately for each company offering coverage in Massachusetts, even if the companies are part of a family of coverages?

Section 3.(b)

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

(i) direct premiums earned, as defined in chapter 176J; direct claims incurred, as defined in chapter 176J;
(ii) medical loss ratio;
(iii) number of members;
(iv) number of distinct groups covered;
(v) number of lives covered;
(vi) realized capitalized gains and losses;
(vii) net income;
(viii) accumulated surplus;
(ix) accumulated reserves;
(x) risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners;
(xi) financial administrative expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;
(xii) marketing and sales expenses, including advertising, member relations, member enrollment expenses;
(xiii) distribution expenses, including commissions, producers, broker and benefit consultant expenses;
(xiv) claims operation expenses, including adjudication, appeals, settlements and expenses associated with paying claims;
(xv) dental administration expenses, including disease management, utilization review, and dental management expenses;
(xvi) network operational expenses, including contracting, dentist relations and dental policy procedures;
(xvii) charitable expenses, including any contributions to tax-exempt foundation and community benefits;
(xviii) board, bureau or association fees;
(xix) any miscellaneous expenses described in detail by expense, including an expense not include in (i) to (xviii), inclusive;
(xx) payroll expenses and the number of employees on the carrier’s payroll;
(xxi) taxes, if any, paid by the carrier to the federal government or to the commonwealth; and
(xxii) any other information deemed necessary by the commissioner.

1) Is it clear that each of the listed items are to be reported for each company, each line of business and for each group size category? For example, for loss ratio and net income, should information be reported separately for each company, line of business and group size category?

2) How should accumulated surplus, accumulated reserves and risk-based capital be reported in this report? Should carriers attempt to report a separate risk-based capital score for each company, line of business and group size category or should one number be reported for each company and not by line of business or group size category?

3) What methods should carriers use to allocate the administrative expenses identified in items (xi) – (xxi) across companies, lines of business and group size categories in the reports when they may not have any cost accounting systems that record these expenses as noted? Should a consistent method be used across the reporting carriers or should carriers choose the best method based on their accounting systems and use this consistently throughout their report? If there should be a consistent method, what method should be used?

Section 3.(c)

"Any carrier required to report under this section, which provides administrative services to 1 or more self-insured groups shall 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 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 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 chapter 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."

1) Is it clear that carriers with insured members are to complete the report for this section for any dental business that they administer in Massachusetts as a third-party administrator for self-funded accounts? Are entities that only operate as third-party administrators for self-funded accounts – and do not have any insured business – required to complete this report for any dental business that they administer in Massachusetts? Is it clear that this report should not include any self-funded employer dental business for an employer that is not administering benefits from Massachusetts?

2) Is it clear that the number of the carrier's self-insured dental customers should only include those customers who coordinate employer-sponsored dental plan benefits in Massachusetts? Is it also clear that the number of members should only include employee subscribers of those employers whose benefits are coordinated out of Massachusetts? Is it also clear that the number of covered lives should not include the subscribers and their dependents who are in self-funded dental plans that are administered outside of Massachusetts?

3) What should be reported for premium and loss ratio? As third-party administrators for self-funded plans, these entities may collect administrative fees, but do not collect premiums in the when administering self-funded accounts. Since third-party administrators are not collecting premiums, what should be reported for loss ratio?

4) What should be reported for net income? Should this represent the difference in the administrative service fees for dental business paid by self-insured customers and the cost of administering this self-funded business? Should the Division of Insurance also collect information about the cost of administering the self-funded dental business?

5) What should be reported for accumulated reserve and accumulated surplus?

6) What should be reported for the percentage of individuals who satisfy Massachusetts mandated benefits? The Division already captures this information in a report associated with M.G.L. c. 176O for mandated health benefits. Since there are not any current mandated dental benefits, should there be anything reported for this item?

7) What other information should be collected by the Division of Insurance?

Section 3.(d)

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

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

1) Are there any items that require additional clarifications?

Section 3.(e) and (f)

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

“The commissioner may waive specific reporting requirements in this section for classes of carriers for which the commissioner deems such reporting requirement to be inapplicable; provided, however, that the commissioner shall 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.”

1) Are there any items that require additional clarifications?

Section 4

“Except as otherwise provided below, this chapter shall apply to all dental benefit plans, including plans issued directly by a carrier, through the connector, or through an intermediary. This chapter shall 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. 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.”

1) Are there any items that require additional clarifications?