ACT 191

S.B. NO. 1073

A Bill for an Act Relating to Dental Service Corporations.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to title 24 to be appropriately designated and to read as follows:

"CHAPTER
DENTAL INSURERS

§ **-1 Definitions.** As used in this chapter:

"Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this chapter, "capitated basis" includes the cost associated with operating staff model facilities.

"Carrier" means a dental insurer, a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, a mutual benefit society, or other entity responsible for the payment of benefits or provision of services under a group contract.

"Commissioner" means the insurance commissioner.

"Copayment" means an amount an enrollee must pay to receive a specific service which is not fully prepaid.

"Dental care services" include the practices, acts, and operations pertaining to dentistry as defined in section 448-1.

"Dental insurance plan" means insurance, as defined in section 431:1-201, for dental care services.

"Dental insurer" means any person who undertakes to provide or to arrange for or administer one or more dental insurance plans and who has met the requirements of chapter 423.

"Dental service corporation" means a corporation established pursuant to section 423-1.

"Discontinuance" means the termination of the contract between a group contract holder and a dental insurer due to the insolvency of the dental insurer, and does not refer to the termination of any agreement between any individual subscriber and a dental insurer.

"Enrollee" means an individual who is covered by a dental insurer.

"Evidence of coverage" means a statement of the essential features and services of the dental insurer coverage that is given to the subscriber by the dental insurer or by the group contract holder.

"Grievance" means a written complaint submitted in accordance with the dental insurer's formal grievance procedure by or on behalf of an enrollee regarding any aspect of the dental insurer relative to the enrollee.

"Group contract" means a contract for dental care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

"Group contract holder" means the person to which a group contract has been issued.

"Individual contract" means a contract for dental care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

"Insolvent" or "insolvency" means that the dental insurer has been declared insolvent and placed under an order of supervision, rehabilitation, or liquidation by the commissioner or a court of competent jurisdiction.

"Net worth" means the excess of total assets over total liabilities; provided that, liabilities shall not include fully subordinated debt.

"Participating provider" means a provider as defined in this section, who, under an express or implied contract with the dental insurer or with its contractor or subcontractor, has agreed to provide dental care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the dental insurer.

"Person" has the same meaning as in section 431:1-212.

"Provider" means any person licensed to practice dentistry as defined in section 448-1.

"Replacement coverage" means the benefits provided by a succeeding carrier.

"Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the dental insurer, or in the case of an individual contract, the person in whose name the contract is issued.

"Uncovered expenditures" means the costs to the dental insurer for dental care services that are the obligation of the dental insurer, for which an enrollee may also be liable in the event of the dental insurer's insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. Uncovered expenditures shall not include expenditures for services when

a provider has agreed not to bill the enrollee even though the provider is not paid by the dental insurer, or for services that are guaranteed, insured, or assumed by a person or organization other than the dental insurer.

§ -2 **Establishment of a dental insurer; certificate of authority.** (a) Any person may apply to the commissioner for a certificate of authority to establish and operate a dental insurer in compliance with this chapter and chapter 423. No person shall establish or operate a dental insurer in this State without meeting the requirements of chapter 423 and obtaining a certificate of authority under this chapter. A foreign corporation may qualify under this chapter, subject to its registration to do business in this State in compliance with all provisions of this chapter and other applicable state laws, including chapter 423.

(b) Any dental service corporation formed and operating pursuant to chapter 423 as of July 1, 2013, shall submit an application for a certificate of authority under subsection (c) within ninety days of July 1, 2013. The applicant may continue to operate until the commissioner acts upon the application. In the event that an application made pursuant to this subsection is denied, the applicant shall thereafter be treated as a dental service corporation whose charter of incorporation has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, official positions, and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

(4) A copy of any contract form made or to be made between any class of providers and the applicant and a copy of any contract made or to be made between third party administrators, marketing consultants, or persons listed in paragraph (3) and the applicant;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, and both a copy of the applicant's most recent audited financial statement and an unaudited current financial statement;

(8) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments, deposits with the State, income and expense

statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by the applicant, if not domiciled in this State, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this State upon whom all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this State may be served;

(10) A statement or map reasonably describing the geographic area or areas to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in section -6;

(14) A list of the names, addresses, and license numbers of all providers or groups of providers with which the applicant has agreements; and

(15) Such other information as the commissioner may require.

(d) If the commissioner finds that the applicant has met the requirements for and is fully entitled thereto under the applicable insurance laws, the commissioner shall issue an appropriate certificate of authority to the applicant. If the commissioner does not so find, the commissioner shall deny the applicant the certificate of authority within a reasonable length of time following filing of the completed application by the applicant. A certificate of authority shall be denied only after the commissioner complies with the requirements of section -13.

(e) The commissioner may adopt rules under chapter 91 for the implementation and administration of this chapter.

§ -3 **Fiduciary responsibilities.** (a) Any director, officer, employee, or partner of a dental insurer who receives, collects, disburses, or invests funds in connection with the activities of an organization shall be responsible for the funds in a fiduciary relationship to the organization.

(b) A dental insurer shall maintain in force a fidelity bond or fidelity insurance on employees, officers, directors, and partners subject to subsection (a) in an amount not less than $250,000 for each dental insurer or a maximum of $5,000,000 in aggregate maintained on behalf of dental insurers owned by a common parent corporation, or a sum as may be prescribed by the commissioner.

§ -4 **Annual reports.** (a) Each dental insurer shall file with the commissioner:

(1) An audit, by an independent certified public accountant or an accounting firm designated by the dental insurer of the financial statements, reporting the financial condition and results of operations of the dental insurer, annually on or before June 1, or a later date as

the commissioner upon request or for cause may specify. The dental insurer, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the dental insurer's designation within fifteen days of receipt of the dental insurer's notice, and the dental insurer shall be required to designate another independent certified public accountant or accounting firm;

(2) A list of the providers who have executed a contract that complies with section -6(d), annually on or before March 1; and

(3) A description of the available grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances, annually on or before March 1.

(b) The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter.

(c) Any dental insurer failing or refusing to submit any of the documents required under this section shall be liable for a penalty in an amount not less than $100 and not more than $500 for each day of delinquency. Penalties collected pursuant to this section shall be deposited into the compliance resolution fund.

§ **-5 Information to subscribers.** (a) The dental insurer shall provide to its subscribers a list of providers and participating providers, upon enrollment and reenrollment.

(b) Every dental insurer shall provide to its subscribers notice of any material change in the operation of the organization that will affect them directly within thirty days of the material change.

(c) The dental insurer shall provide to subscribers information on how dental care services may be obtained, where additional information on access to dental care services may be obtained, a description of the internal grievance procedures, and a telephone number for a subscriber to contact the dental insurer at no cost to the subscriber.

(d) For the purpose of this section, "material change" means any major change in provider or participating provider agreements.

§ **-6 Protection against insolvency; net solvency report.** (a) Net worth requirements are as follows:

(1) Before issuing any certificate of authority, the commissioner shall require that the dental insurer has an initial net worth of $2,000,000 and shall thereafter maintain the minimum net worth required under paragraph (2);

(2) Except as provided in paragraphs (3) and (4), every dental insurer shall maintain a minimum net worth equal to the greater of:

(A) $2,000,000;

(B) Two per cent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first $150,000,000 of premium revenues and one per cent of annual premium revenues on the premium revenues in excess of $150,000,000;

(C) An amount equal to the sum of three months uncovered dental care expenditures as reported on the most recent financial statement filed with the commissioner; or

(D) An amount equal to eight per cent of annual dental care expenditures except those paid on a capitated basis as reported on the most recent financial statement filed with the commissioner;

(3) The minimum net worth requirement set forth in paragraph (2)(A) shall be phased in as follows:

(A) Seventy-five per cent of the required amount by January 1, 2016; and

(B) One hundred per cent of the required amount by December 31, 2017; and

(4) The following shall apply in determining compliance with the requirements of this subsection:

(A) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated;

(B) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses; and

(C) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(b) Deposit requirements are as follows:

(1) Unless otherwise provided in this subsection, each dental insurer shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than $300,000;

(2) A dental service corporation formed and operating pursuant to chapter 423 that is in operation on July 1, 2013, shall make a deposit equal to $150,000. Within one year after January 1, 2014, a dental service corporation originally formed pursuant to chapter 423 that is reconstituted under this chapter and in operation on January 1, 2014, shall make an additional deposit of $150,000 for a total of $300,000;

(3) Deposits shall be an asset of the dental insurer in the determination of net worth;

(4) All income from deposits shall be an asset of the dental insurer. A dental insurer that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted;

(5) The deposit shall be used to protect the interests of the dental insurer's enrollees and to assure continuation of dental care services to enrollees of a dental insurer which is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the dental insurer is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of article 15 of chapter 431; and

(6) The commissioner may reduce or eliminate the deposit requirement if the dental insurer deposits with the director of finance of this State, or the commissioner, or other official body of the state or

jurisdiction of domicile of such dental insurer, for the protection of all subscribers and enrollees, wherever located, cash, acceptable securities, or surety, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

(c) Every dental insurer, when determining liabilities, shall include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for dental care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of claims. These liabilities shall be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the dental insurer.

(d) Every contract between a dental insurer and a participating provider shall be in writing and shall set forth that in the event the dental insurer fails to pay for dental care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the dental insurer. In the event that a contract with a participating provider has not been reduced to writing as required by this subsection or that a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the dental insurer. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the dental insurer.

(e) The commissioner shall require that each dental insurer have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in participating provider contracts that obligate the provider to provide dental care services for the duration of the period after the dental insurer's insolvency for which premium payment has been made;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements acceptable to the commissioner to assure that benefits are continued as specified in this subsection.

(f) An agreement to provide dental care services between a participating provider and a dental insurer shall require that a participating provider shall give the dental insurer at least sixty days' advance notice in the event of termination.

(g) Each dental insurer shall prepare for review by the commissioner on or before the forty-fifth day of each quarter, a copy of its quarterly net solvency report verified by at least two principal officers. The commissioner may prescribe the forms on which the reports are to be prepared. Every dental insurer shall maintain a copy of its current net solvency report on the premises of its primary place of business.

(h) The commissioner may order an examination, subject to article 2 of chapter 431, to determine whether a dental insurer is in compliance with this section. Any dental insurer that fails or refuses to prepare or produce for review the quarterly net solvency report or any of the documents as required by this section shall be liable for a penalty pursuant to section -4(c).

§ -7 **Uncovered expenditures insolvency deposit.** (a) If, at any time, uncovered expenditures exceed ten per cent of total dental care expenditures, a dental insurer shall place with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, an uncovered expenditures insolvency deposit consisting of cash or securities that are acceptable to the commissioner. Such deposit shall have, at all times, a fair market value in an amount of one-hundred-twenty per cent of the dental insurer's outstanding liability for uncovered expenditures for enrollees in this State, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a dental insurer is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under section -6 and is an asset of the dental insurer in the determination of net worth. All income from the deposits or trust accounts subject to this section shall be an asset of the dental insurer and may be withdrawn from the deposit or trust account quarterly with the approval of the commissioner.

(c) A dental insurer that has made a deposit may withdraw that deposit or any part of the deposit if:

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under subsection (a) is reduced or eliminated.

Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.

(d) The deposit required under this section shall be held in trust and shall be used only as provided in this section. The commissioner may use the deposit of an insolvent dental insurer for administrative costs associated with administering the deposit and payment of claims of enrollees of this State for uncovered expenditures in this State. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the dental insurer.

(e) The commissioner may prescribe the time, manner, and form for filing claims under subsection (d).

(f) The commissioner may require dental insurers to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

§ -8 **Reserve credit for reinsurance.** Any dental insurer that takes credit for reserves on risks ceded to a reinsurer shall be subject to provisions of article 4A of chapter 431.

§ -9 **Replacement coverage.** (a) Any carrier providing replacement coverage with respect to group dental benefits within a period of sixty days from the date of discontinuance of a prior dental insurer contract or policy providing such dental benefits shall immediately cover all enrollees who were validly covered under the previous dental insurer contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding

carrier's contract, regardless of any provisions of the contract relating to active employment.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to a claim for benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

§ -10 **Powers of insurers and hospital and medical service corporations.** (a) An insurance company licensed in this State, or a hospital or medical service corporation authorized to do business in this State, either directly or through a subsidiary or affiliate, may organize and operate a dental insurer under the provisions of this chapter. Notwithstanding any other law to the contrary, any two or more insurance companies, hospital or medical service corporations, dental insurers, or subsidiaries or affiliates thereof, may jointly organize and operate a dental insurer. The business of insurance is deemed to include the providing of dental care services by a dental insurer owned or operated by an insurer or a subsidiary thereof.

(b) Notwithstanding any contrary provision of laws pertaining to insurance or hospital or medical service corporations under chapter 431, 432, or 432D, an insurer or a hospital or medical service corporation may contract with a dental insurer to provide insurance or similar protection against the cost of dental care services provided through dental insurers and to provide coverage in the event of the failure of the dental insurer to meet its obligations. The enrollees of a dental insurer constitute a group permitted under chapter 431, 432, or 432D. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to dental insurers for dental care services rendered by providers.

§ -11 **Examinations.** (a) The commissioner may examine the affairs of any dental insurer or of any providers with whom a dental insurer has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State.

(b) Every dental insurer and provider shall submit its books and records for examination and in every way facilitate the completion of an examination by the commissioner. In the event a dental insurer or a provider fails to comply with the directions of the commissioner, the commissioner may examine the affiliates of the dental insurer or provider to obtain the information. For the purpose of examinations, the commissioner may administer oaths to and examine the officers and agents of the dental insurer and the principals of providers concerning their business.

(c) The cost of examinations under this section shall be assessed against the dental insurer or provider being examined and shall be remitted to the commissioner for deposit into the compliance resolution fund.

(d) In lieu of the commissioner's own examination, the commissioner may accept the report of an examination made by the commissioner or the appropriate official of another state.

§ -12 **Fees.** (a) The commissioner shall collect the following fees:

(1) For filing an application for a certificate of authority or amendment thereto, $600; and

(2) For all services subsequent to the issuance of a certificate of authority, including extension of the certificate of authority, $400.

(b) No certificate of authority shall contain an expiration date, but all certificates of authority shall be extended from time to time in order to continue to be valid. When the commissioner issues or extends a certificate of authority, the commissioner shall determine the date prior to which the certificate of authority is next required to be extended, the extension date, and shall so notify the insurer holding the certificate of authority in writing. If the fee for extension is not paid before or on the extension date, a penalty shall be imposed in the amount of fifty per cent of the fee. If the fee and the penalty are not paid within thirty days immediately following the extension date, the commissioner may suspend the certificate of authority and shall not reinstate the certificate of authority until the fee and penalty have been paid.

(c) All fees and penalties collected pursuant to this section shall be deposited into the compliance resolution fund.

§ -13 **Suspension, revocation, or denial of certificate of authority.** (a) The commissioner may suspend, revoke, or refuse to extend any certificate of authority issued under this chapter and may deny any application for a certificate of authority if the commissioner finds that:

(1) The dental insurer is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section -2, unless amendments to such submissions have been filed with and approved by the commissioner;

(2) The dental insurer or applicant does not provide or arrange for basic dental care services;

(3) The dental insurer or applicant is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(4) The dental insurer has failed to correct, within the time prescribed by subsection (b), any deficiency occurring due to the impairment of the dental insurer's prescribed minimum net worth;

(5) The dental insurer, applicant, or any person acting on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(6) The dental insurer, applicant, or any person acting on its behalf fails or refuses to produce or submit any of the documents required under sections -4 and -6;

(7) The operation or continued operation of the dental insurer would be hazardous to its enrollees; or

(8) The dental insurer or applicant has otherwise failed to substantially comply with this chapter.

(b) The following shall pertain when insufficient net worth is maintained:

(1) Whenever the commissioner finds that the net worth maintained by any dental insurer subject to this chapter is less than the minimum net worth required, the commissioner shall give written notice to the dental insurer of the amount of the deficiency and shall require the dental insurer to:

(A) File with the commissioner a plan for correction of the deficiency acceptable to the commissioner; and

(B) Correct the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the commissioner. A deficiency in

net worth shall be deemed an impairment. Failure to correct an impairment within the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the dental insurer in conservation, rehabilitation, or liquidation; and

(2) Unless allowed by the commissioner, no dental insurer or person acting on its behalf, directly or indirectly, may renew, issue, or deliver any certificate, agreement, or contract of coverage in this State, for which a premium is charged or collected, while the dental insurer is impaired and the fact of the impairment is known to the dental insurer or person. The existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement, or contract if an enrollee exercises an option granted under the plan to obtain new, renewed, or converted coverage.

(c) A certificate of authority shall be suspended, revoked, or not extended, or an application for a certificate of authority denied, or an administrative fine imposed, only after compliance with the following requirements:

(1) Suspension or revocation of a certificate of authority, refusal to extend a certificate of authority, denial of an application, or imposition of an administrative fine pursuant to section -15(a) shall be by written order of the commissioner, which shall be sent to the dental insurer or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, refusal to extend, denial, or administrative fine is based. The insurer or applicant may request in writing a hearing pursuant to section 431:2-308; and

(2) If the dental insurer or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing stating a specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing and a specific place for the hearing. Notice of hearing shall be delivered to the insurer or applicant by certified or registered mail.

(d) When the certificate of authority of a dental insurer is suspended, the dental insurer shall not, during the period of suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing subscribers, and shall not engage in any advertising or solicitation whatsoever.

(e) When the certificate of authority of a dental insurer is revoked, the insurer, immediately following the effective date of the order of revocation, shall proceed to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the insurer. It shall engage in no further advertising or solicitation whatsoever. The commissioner, by written order, may permit any further operation of the insurer as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing dental care coverage.

§ **-14 Summary orders and supervision.** (a) Whenever the commissioner determines that the financial condition of any dental insurer is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this chapter, the commissioner, after notice and hearing, may order the dental insurer to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to:

(1) Reducing the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;
(2) Reducing the volume of new business being accepted;
(3) Reducing expenses by specified methods;
(4) Suspending or limiting the writing of new business for a period of time;
(5) Increasing the dental insurer's capital and surplus by contribution; or
(6) Taking any other steps as the commissioner may deem appropriate under the circumstances.

(b) For purposes of this section, the violation by a dental insurer of any law of this State to which the dental insurer is subject shall be deemed a violation of this chapter.

(c) The commissioner is authorized to set uniform standards and criteria for early warning that the continued operation of any dental insurer might be hazardous to its enrollees, creditors, or the general public, and to set standards for evaluating the financial condition of any dental insurer, which standards shall be consistent with the purposes expressed in subsection (a).

(d) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of article 15 of chapter 431.

§ -15 **Administrative fines and enforcement.** (a) The commissioner, in addition to or in lieu of suspension or revocation of a certificate of authority pursuant to section -13, may levy an administrative fine upon a dental insurer in an amount not less than $500 and not more than $50,000. The dental insurer may request, in writing, a hearing pursuant to section -13. The order levying the fine shall specify the period within which the fine shall be fully paid, which shall not be less than thirty nor more than forty-five days from the date of the order. Upon failure to pay the fine when due, the commissioner shall revoke the insurer's certificate of authority if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner. Any fine so collected shall be remitted by the commissioner to the director of finance and shall be placed to the credit of the compliance resolution fund.

(b) If the commissioner, for any reason, has cause to believe that any violation of this chapter has occurred or is threatened, the commissioner may give notice to a dental insurer and its representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to any suspected violation. In the event it appears that any violation has occurred or is threatened, the commissioner may attempt to arrive at an adequate and effective means of correcting or preventing the violation. Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the dental insurer, no order may result from a conference until the requirements of this section are satisfied.

(c) The commissioner may issue an order directing a dental insurer or a representative of a dental insurer to cease and desist from engaging in any act or practice in violation of the provisions of this chapter. Any person aggrieved by an order of the commissioner under this section may obtain judicial review of the order in the manner provided for by chapter 91.

(d) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of non-

compliance with a cease and desist order issued pursuant to subsection (c), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in any court of competent jurisdiction.

§ -16 **Statutory construction and relationship to other laws.** (a) Except as provided in subsection (c) and otherwise provided in this chapter, the insurance laws shall not apply to the activities authorized and regulated under this chapter of any dental insurer granted a certificate of authority under this chapter.

(b) Solicitation of enrollees by a dental insurer granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by providers.

(c) Articles 2, 2D, 13, and 15 of chapter 431, and the powers granted by those provisions to the commissioner shall apply to dental insurers, so long as the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations.

§ -17 **Acquisition of control of or merger of a dental insurer.** No person may make a tender for or a request or invitation for tenders of, enter into an agreement to exchange securities for, or acquire in the open market or otherwise, any voting security of a dental insurer or enter into any other agreement if, after the consummation thereof, that person, directly or indirectly, or by conversion or by exercise of any right to acquire, would be in control of the dental insurer, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a dental insurer, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the dental insurer information required by section 431:11-104 and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner. Approval by the commissioner shall be governed by section 431:11-104(d); provided that if no action is taken by the commissioner within thirty days, the offer, request, invitation, agreement, or acquisition shall be deemed approved.

§ -18 **Federally funded programs; exemption.** Requirements provided in this chapter relating to mandated coverages or essential health benefits shall not be applicable to any dental insurer offering dental insurance under a federally funded program under the Social Security Act, as amended; provided that this exemption shall apply only to that part of the dental insurer's business under the federally funded program.

§ -19 **Coordination of benefits.** (a) Dental insurers are required to adopt provisions for coordination of benefits to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

(b) Provisions adopted pursuant to subsection (a) for the coordination of benefits shall be consistent with the coordination of benefits provisions that are in general use in the State for coordinating coverage between two or more group health insurance or health care plans.

§ -20 **Disclosure of dental care coverage and benefits.** In order to ensure that all individuals understand their dental care options and are able to make informed decisions, all dental insurers shall provide current and prospective sub-

scribers with written disclosure of coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage.

The information provided shall be current, understandable, and available prior to enrollment, and upon request after enrollment. A policy or contract provided to a subscriber which describes coverages and benefits shall be in conformance with part I of article 10 of chapter 431.

§ -21 **Federal law compliance.** All dental insurers shall comply with applicable federal law. The commissioner shall enforce the consumer protections and market reforms relating to insurance as set forth in the federal Patient Protection and Affordable Care Act, Public Law 111-148."

SECTION 2. This Act shall take effect on July 1, 2013.

(Approved June 25, 2013.)