211 CMR 156.00: DENTAL INSURANCE

Section

156.01: Purpose

The purpose of 211 CMR 156.00 is to implement the provisions of M.G.L. c. 176X.

156.02: Applicability and Scope

211 CMR 156.00 applies to all Dental Benefit Plans offered, made effective, issued or renewed in Massachusetts to any Individual, Group Association, or Employer Group, whether issued directly by a Carrier, through the Connector, or through a Group Association.

156.03: Definitions

Actual Dental Loss Ratio. Incurred Claims during a specified period for covered dental services plus Qualified Quality Improvement Activity expenses, which is then divided by earned dental premiums reduced by Federal and State Taxes, Assessments, and Licensing or Regulatory Fees.

Actuarial Opinion. A signed written statement by a qualified actuary, which certifies that the actuarial assumptions, methods, and contract forms utilized by the Carrier in establishing premium rates for Dental Benefit Plans comply with all the requirements of M.G.L. c. 176X, 211 CMR 156.00, and any other applicable law or regulation.

Base Rates or Group Product Base Rates. The rate to be charged to Individuals and their Dependents and/or Businesses for all Eligible Employees and Eligible Dependents prior to the application of Rating Adjustment Factors.

Carrier. An insurer or other entity offering insured Dental Benefit Plans in the Commonwealth, which may include an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a medical service corporation organized under M.G.L. c. 176B; or a dental service corporation organized under M.G.L. c. 176E.

Commissioner. The Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6, or their designee.

Connector. The Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q.

Dental Benefit Plan or Plan. Any insured Stand-alone Dental Benefit Plan that covers oral surgical care, Dental Services, dental procedures, or benefits covered by any individual, general, blanket, or group policy of insurance issued by a Carrier.

Dental Care. The diagnosis or treatment (preventive or otherwise) of dental disease of teeth and/or their supporting structures.

(Mass. Register #1519, 4/12/2024)

156.03: continued

Dental Provider. A practitioner that is appropriately licensed to provide Dental Services.

Dental Service. The dental services ordinarily provided by registered dentists and dental practices in accordance with accepted practices in the community where the services are rendered.

Division. The Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Eligible Dependent. The spouse or child of an Individual or Business' Eligible Employee, subject to the applicable terms of the Dental Benefit Plan covering such Individual or Eligible Employee. The child of an Individual or Eligible Employee shall be considered an Eligible Dependent until at least the child's 26th birthday or without regard to age, so long as the dependent, who is covered under the membership of their parent as a member of a family group, is mentally or physically incapable of earning their own living due to disability.

Eligible Employee. Any person employed by an employer, including seasonal and temporary staff, but excluding business owners and those holding more than 2% of stock ownership.

Employer Group or Business. Any sole proprietorship, firm, corporation, partnership, or other entity that employs Eligible Employees.

Financial Impairment. A condition in which, based on the overall condition of the Carrier as determined by the Commissioner, the Carrier is, or if subjected to the provisions of 211 CMR 156.00 could reasonably be expected to be, insolvent, or otherwise in an unsound financial condition such as to render its further transactions of business hazardous to the public or its policyholders or Members, or is compelled to compromise, or attempt to compromise, with its creditors or claimants on the grounds that it is financially unable to pay its claims.

Federal and State Taxes, Assessments and Licensing or Regulatory Fees. Incurred federal and state income, premium or other taxes and assessments, and licensing or regulatory fees associated with a Carrier's Dental Benefit Plans.

Fraud, Waste, and Abuse Recoveries. The amount of claims payments recovered through fraud, waste, and abuse reduction efforts, not to exceed the amount of fraud, waste, and abuse reduction expenses.

Group Association. A group formed as an association or a trust, which may obtain insurance coverage for the benefit of members of one or more associations.

Incurred Claims. Dental Services costs, including eligible Fraud, Waste, and Abuse Recoveries, incurred in a reporting period by a Dental Benefit Plan to be paid to Dental Providers or covered persons for activities by a Dental Provider.

Individual. An individual who is a Resident of the Commonwealth.

Insured. Any policyholder, certificate holder, subscriber, Member, or other person on whose behalf the Carrier is obligated to pay for and/or provide Dental Care services.

Large Group. Employer Groups that employ 51 or more Eligible Employees.

Market. The Individual, Group Association, Small Group, and/or Large Group Market(s) in which a Carrier offers a Dental Benefit Plan.

Member. Any person enrolled in a Dental Benefit Plan.

Minimum Dental Loss Ratio. The Minimum Dental Loss Ratio for insured Dental Benefit Plans issued or renewed in Massachusetts is 83%.

156.03: continued

Projected Dental Loss Ratio. Projected Incurred Claims for a specified period for covered Dental Care services plus projected Qualified Quality Improvement Activity expenses, which is then divided by projected earned dental premiums reduced by projected Federal and State Taxes, Assessments, and Licensing or Regulatory Fees.

Qualified Quality Improvement Activity or QIA. An activity designed to improve dental quality that is performed equitably, including activities performed by or through a provider that are primarily designed to improve dental outcomes, including, but not limited to, activities with a likelihood of reducing disparities among specified populations or which promote and enhance dental wellness. A QIA is directed to individual patients or incurred for the benefit of specified segments of patients, increases the likelihood of desired clinical outcomes that are capable of being objectively measured and/or which produce verifiable results, requires expertise, increases wellness and promotes health activities, and is directed toward individual Members of a Carrier's plans or segments of Members, as well as populations other than Members (as long as no additional costs are incurred for the non-Members, and as long as the activity can be supported by evidence-based medicine, best clinical practices, or criteria issued by professional associations that meet all the requirements of 45 CFR158.150(b)). A QIA does not include any activities that are identified under 45 CFR 158.150(c); that have any overlap with administrative expense items specified under M.G.L. c. 176X, § 2(b)(i) through (x); that have any marketing component that displays the name of the Carrier; or which are paid for by the Carrier to any affiliate of the Carrier in any way, directly or indirectly.

Rating Adjustment Factor. A factor that is based on actuarial principles of risk segmentation, that is not restricted by any state or federal rule, and that is used to derive the premium that is charged to a particular Individual or Employer Group.

Rating Period. The period for which premium rates established by a Carrier are in effect.

Resident. A natural person living in the Commonwealth, but the confinement of a person in a nursing home, hospital, or other institution shall not by itself be sufficient to qualify a person as a Resident.

Small Group. Employer Group that employs 50 or fewer Eligible Employees.

Stand-alone Dental Benefit Plan. An insured dental plan issued by a Carrier to cover Dental Services that is otherwise not reported through medical loss ratio requirements under state or federal law.

Trend in Dental Care Expenses. The projected change in Dental Care Costs.

156.04: Coverage Standards

(1) Evidences of Coverage. Carriers are to file all insured Dental Benefit Plans offered under 211 CMR 156.00 with the Division.

(a) All such Plans are to be reviewed for compliance with M.G.L. c. 175, § 2B.

(b) Individually issued Dental Benefit Plans are to comply with the requirements of 211 CMR 42.00: *Health Maintenance Organizations (HMOs)*.

(c) Plans that provide or arrange for the delivery of dental benefits through a network of Dental Providers or use utilization management in the review of the necessity of certain Dental Services are to comply with the requirements of 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*, as noted in 211 CMR 52.01: *Applicability*.

(d) Plans that provide or arrange for the delivery of dental benefits through a network of Dental Providers and include dental networks that differ from those of a Dental Benefit Plan's overall network should prominently display on all Plan documents, including provider directory materials, a provider network name that distinguishes the network of the Plan from the other networks offered by the Carrier.

(e) Plans that permit both an in-network and an out-of-network level of dental benefits are to comply with the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements*.

156.04: continued

(2) Issuing Coverage.

(a) 1. No Carrier may exclude any Individual, Eligible Employee, or Eligible Dependent from a Dental Benefit Plan on the basis of any impermissible factors, including but not limited to race, color, religious creed, national origin, sex, gender identity, sexual orientation, genetic information, pregnancy, ancestry, or status as a veteran.

2. No Carrier may modify the coverage of an Individual, Eligible Employee, or Eligible Dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or conditions otherwise covered by the Dental Benefit Plan, except as permitted under 211 CMR 156.00.

3. Every Carrier must make appropriate disclosures in plain language and provide access to information assistance to prospective group Insureds and prospective individual Insureds, as part of its solicitation and sales material, of:

a. renewal provisions;

b. rating limitations according to 211 CMR 156.05; and

c. availability of Dental Benefit Plans, including, but not limited to, situations where a plan has a dental provider network that is limited to a particular service area or to employees that live in the service area.

(b) Carriers are permitted to underwrite Dental Benefit Plans that are issued to Individuals, provided that the applicant completes a dental coverage application and the Carrier uses the information from the application to determine whether to issue coverage based on its policy for underwriting individual dental policies. Carriers may apply waiting periods, deductibles, benefit limitations, or exclusions as a condition of issuing coverage, provided that the applicant is made aware of and is provided with complete written information regarding all conditions that differ from the coverage originally applied for. When issuing Individual Dental Benefit Plans, Carriers are required to prominently and clearly identify the renewal conditions of the policy on the cover page of the Individual policy, in a manner that is consistent with the requirements set forth in 211 CMR 42.00: *Health Maintenance Organizations (HMOs)*.

(c) Carriers are permitted to underwrite Dental Benefit Plans to be issued to Group Associations and may underwrite coverage issued to Individuals through Group Associations, provided that the applicant completes a dental coverage application and the Carrier uses the information from the application to determine whether to issue coverage based on its individual coverage policy. Carriers may apply waiting periods, deductibles, benefit limitations, or exclusions as a condition of issuing coverage, provided that the applicant is made aware of and is provided with complete written information regarding all conditions that differ from the coverage originally applied for. When issuing certificates of coverage for Group Association Dental Benefit Plans, Carriers are required to prominently and clearly identify the renewal conditions on the cover page of the certificate of coverage.

(d) Carriers are permitted to underwrite the issuance of group dental coverage to Employer Groups, but are not permitted to underwrite coverage issued to Eligible Employees and their eligible dependents. Carriers may apply waiting periods, deductibles, benefit limitations, or exclusions as a condition of issuing coverage to an Employer Group, provided that the applicant is made aware of and is provided with complete written information regarding all conditions that differ from the coverage originally applied for. When issuing certificates of coverage to Employer Groups for Dental Benefit Plans, Carriers are required to prominently and clearly identify within the certificates all continuation of coverage provisions, including, but not limited, to those required under federal COBRA protections, in the event employment-based coverage is lost due to a qualifying event.

156.05: Restrictions Relating to Premium Rates

Carriers may develop Base Rates that are based on the collective experience of all Individuals, Group Associations, Small Groups, and Large Groups to which the Dental Benefit Plans are marketed, or Carriers may develop Base Rates for any single or combination of Individual, Group Association, Small Group, or Large Group Markets in which they offer Dental Benefit Plans. Premiums charged must satisfy the following requirements:

156.05: continued

Premium Calculations

(1) In calculating the premium to be charged, a Carrier shall develop a Base Rate and may develop and use one or more Rating Adjustment Factors, provided that such Rating Adjustment Factors are used in connection with all products offered to those eligible within a Market.

(a) Carriers may develop one Base Rate and set of Rating Adjustment Factors that apply to all Markets; or

(b) Carriers may develop separate Base Rates and Rating Adjustment Factors for each or combination of each of the Markets in which it offers Dental Benefit Plans.

(2) In calculating the premium to be charged, a Carrier shall develop a Base Rate and may develop and use only Rating Adjustment Factors that are based on sound actuarial principles about the segmentation of risk and are not discriminatory under state or federal law.

(a) Age Rating Adjustment Factor. If a Carrier applies an age Rating Adjustment Factor, the Carrier must apply the age Rating Adjustment Factor in accordance with guidance provided by the Commissioner.

(b) Area Rating Adjustment Factors.

1. The area Rating Adjustment Factor for each distinct region in 211 CMR 156.05(2)(b) must range from not less than 0.8 to not more than 1.2.

2. The permissible regions are based on the following zip code groupings which refer to the first three digits of the zip code for each Business or Individual:

i. 010 through 013;
ii. 014 through 016;
iii. 017 and 020;
iv. 018 through 019;
v. 021 through 022 and 024;
vi. 023 and 027; and
vii. 025 through 026,

except that a Carrier may combine the zip code groupings outlined in 211 CMR 156.05(2)(b)2.ii., iii., and iv. into one region or combine the zip code groupings outlined in 211 CMR 156.05(2)(b)2.ii., iii., iv., and v. into one region for all of its Dental Benefit Plans subject to 211 CMR 156.00, or use regions based on groupings of counties that roughly approximate the zip code groupings.

3. If a Carrier chooses to establish area Rating Adjustment Factors, it must apply the Rating Adjustment Factors to all Members of a Market. The area Rating Adjustment Factor for an Employer Group will be based upon the head office location of the Employer Group and the area Rating Adjustment Factor for an Individual will be based on the location of the Individual's residence.

(c) All Other Rating Adjustment Factors. All other Rating Adjustment Factors may only be used if based on an actuarially sound basis, are considered nondiscriminatory, and only when approved as part of a dental rate filing.

156.06: Submission and Review of Rate Filings

(1) Definitions. For rate filings submitted pursuant to 211 CMR 156.06(2), the following definitions also shall apply:

(a) Capital Costs and Depreciation Expenses. All expenses associated with depreciation (depreciation for electronic data processing, equipment, software, and occupancy); capital acquisitions (acquisition of capital assets, including lease payments that were paid or incurred during the year); capital costs on behalf of a clinic (expenditures for capital and lease payments incurred or paid during the year on behalf of a clinic; or part of a partnership, joint venture, integration, or affiliation agreement); and other capital (other costs that are directly associated with the incurring of capital costs, such as legal or administrative costs, incurred or paid during the year).

(b) Charitable Contributions Expenses. All contributions to tax-exempt foundations and charities, not related to the company business enterprises.

(c) Claim Completion Method. Any actuarial method used to quantify Claims which have been incurred but not yet paid.

156.06: continued

(d) Claims Operations Expenses. All expenses associated with Claims adjudication and adjustment of Claims, appeals, Claims settlement, coordination of benefits processing, maintenance of the Claims system, printing of Claims forms, Claim audit function, electronic data interchange expenses associated with Claims processing, and fraud investigation.

(e) Distribution Expenses. All expenses associated with distribution and sale of dental products, including commissions, producer, broker and benefit consultant fees, other fees, commission processing, and account reporting to brokers, agents, and producers.

(f) Financial Administration Expenses. All expenses associated with underwriting, auditing, actuarial, financial analysis, investment-related expenses (not included elsewhere), treasury, and reinsurance.

(g) General Administration Expenses. All expenses associated with payroll administration expenses and payroll taxes (salaries, benefits and payroll taxes); real estate expenses (company building and other taxes and expenses of owned real estate, excluding home office employee expenses and rent [not allocated elsewhere] and insurance on real estate); regulatory compliance and government relations (federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, preparation and filing of financial, utilization, statistical and quality reports, and administration of government programs); board, bureau, or association fees (Board of Directors, Bureau and association fees paid or expensed during the calendar year); other administration (information technology, senior management, outsourcing [not allocated elsewhere], insurance except on real estate, equipment rental, travel [not allocated elsewhere], certification and accreditation fees, legal fees and expenses before administrative and legal bodies, and other general administrative expenses); and negative adjustment for reimbursement from uninsured plans (all revenue receipts from uninsured plans [including excess pharmaceutical rebates and administrative fees net of expenses] and reimbursements from fiscal intermediaries, including administrative fees net of expenses from the government).

(h) Marketing and Sales Expenses. All expenses associated with billing and Member enrollment (group and individual billing, Member enrollment, premium collection, and reconciliation functions); customer service and Member relations (individual, group or provider support relating to membership, enrollment, grievance resolution, specialized phone services and equipment, consumer services, and consumer information); product management, marketing and sales (management and marketing of current products, including product promotion and advertising, marketing materials, changes or additions to current products, sales, pricing, and enrollee education regarding coverage prior to the sale); and product development: (product design and development for new products not currently offered, major systems development associated with the new products, and integrated system network development).

(i) Dental Administration Expenses. All expenses associated with quality assurance and cost containment (dental and disease management and wellness initiatives other than for education), Dental Care quality assurance, appeals, case management, fraud detection and prevention, utilization review, practice protocol development, peer review, outcomes analysis related to existing products, nurse triage, dental management, and other Dental Care evaluation activities; wellness and dental education (wellness and dental promotion, disease prevention, Member education and materials, and outreach services); and dental research (outcomes research, dental research programs, and development of new dental management programs not currently offered, major systems development, and integrated system network development).

(j) Miscellaneous Expenditures Expenses. All other expenses that are not classified expenses, including all collection and bank service charges, printing, office supplies, postage, and telephone (not allocated elsewhere).

(k) Network Operations Expenses. All expenses associated with provider contracting negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, administration of provider capitation and settlements, dentist relations, dental policy procedures, network access fees, and credentialing.

156.06: continued

(l) Taxes, Assessments and Fines Paid to Federal, State or Local Governments (as Expenses). All expenses associated with taxes (including, but not limited to, state premium taxes, state and local insurance taxes, federal taxes, except taxes on capital gains, state income tax, state sales tax, and other sales taxes not included with the cost of goods purchased); assessments, fees and other amounts paid to regulatory agencies (assessments, fees, or other amounts paid to state or local government, but does not include taxes or fines or penalties paid to any government agency); and fines and penalties paid to regulatory agencies (penalties and fines paid to government agencies).

(2) Content of Rate Filings. A Carrier's submission shall be submitted in a format specified by the Commissioner and shall show the company's development of the filed rates, explaining how they apply to each Market in which the Carrier offers coverage. The filing shall contain at least the following information:

(a) Summary rate information for each product, including:

1. proposed rate change compared to rates in effect 12 months before proposed effective date;
2. number of currently enrolled Members impacted by the proposed rate change, presented as:
    a. number of Employer Groups and covered employees/dependents renewing by month; and
    b. individual accounts and covered Individuals/dependents renewing by month; and
3. maximum increase for any Employer Group or Individual covered under the proposed rate change.

(b) Number of Member months of coverage reported for each of the latest available 12 months for products issued or renewed, as well as the number of Member months projected to be impacted by the proposed rate increase.

(c) A three-year history of premium, dental Claims (including capitation and non-Claims expenses) for the Carrier’s Massachusetts book of business and national book of business, separating by Market, where applicable, differentiating among:

1. preventive Dental Care visits and cleanings;
2. basic restorative Dental Services;
3. major Dental Services; and
4. orthodontic care.

The analysis should explain any differences between what is included in the filing and what normally is included in the Carrier's financial statements. The Carrier also should submit proposed assumptions about Trend in Dental Care Expenses. Annual price and use assumptions for Trend in Dental Care Expenses for fee-for-service expenses should be provided for each year in the projection period, and the Carrier must indicate how many months of each year are used in the analysis. The Carrier should indicate where leverage assumptions are included. Trend in Dental Care Expenses for fee-for-service expenses should reflect provider price increases whereas utilization may include mix of services and mix of providers. The Trend in Dental Care Expenses for fee-for-service expenses information should include the actuarial basis for all changes in Trend in Dental Care Expenses for fee-for-service expenses, including all relevant studies used to derive the factors.

(d) The Carrier's administrative expenses and per Member per month administrative expenses relevant to products issued or renewed and used in the development of the filing, for the two years prior to the submission of the rate filing for each of the following categories:

1. expenses for capital costs and depreciation;
2. expenses for charitable contributions;
3. expenses for Claims operations;
4. expenses for distribution;
5. expenses for financial administration;
6. expenses for general administration;
7. expenses for marketing and sales;
8. expenses for dental administration, with specific detail on costs related to programs that improve Dental Care quality;

156.06: continued

9. expenses for miscellaneous expenditures described in detail;
10. expenses for network operations;
11. expenses for taxes, assessments and fines paid to federal, state or local governments; and
12. total administrative expenses [subtotaling 211 CMR 156.06(2)(d)1. through 11.].

The Carrier also should submit projected increases in administrative expenses per Member per month that the Carrier is using to project administrative expenses forward to the period for which the rates will be effective. The trend information should include an explanation for all significant changes in the Carrier's administrative expenses due to one-time costs, including where changes in administrative expenses may be caused by regulatory requirements or efforts to contain Dental Care delivery costs, an explanation of the projected cost and cost per Member per month that can be attributed to each regulatory requirement or effort to contain Dental Care delivery costs, and the method that the Carrier is using to allocate any companywide expenses to the dental line of business.

(e) The Carrier's contribution to surplus, relevant to products issued or renewed according to M.G.L. c. 176X, both in the aggregate, on a normalized per-Member-per-month basis, and as a percentage of premium for the two years prior to the submission of the rate filing. The Carrier also should identify the contribution to surplus included in the rate filing on a per-Member-per-month basis and as a percentage of premium and should provide a detailed explanation of the reasons that the contribution to surplus has been filed at that level, as well as the contribution to surplus levels that the Carrier is using in all other lines of coverage. The Carrier should describe the method used to quantify the contribution to surplus in the proposed rates.

(f) The three-year historic Actual Dental Loss Ratio for the rates, relevant to products issued or renewed, and the Projected Dental Loss Ratios for the one-year period during which rates will be in effect.

(g) Methodology for Calculating and Reporting Dental Loss Ratio (DLR), for the purposes of M.G.L. c. 176X, § 2(d), the DLR of a Dental Benefit Plan shall be calculated and reported on a calculation worksheet defined by the Commissioner and based on the current federal methodology used by the federal Centers for Medicare and Medicare Services (CMS) for calculating and reporting Medical Loss Ratio rounded to the third decimal place. Unless contrary to the current CMS methodology for calculating and reporting DLR, or unless otherwise determined by the Commissioner, the following items shall be deemed to be an Administrative Cost Expenditure for the purposes of calculating and reporting the Dental Loss Ratios of Dental Benefit Plans for M.G.L. c. 176X:

1. Financial administration expenses;
2. Marketing and sales expenses;
3. Distribution expenses;
4. Claims operations expenses;
5. Dental administration expenses, such as disease management, care management, utilization review, and dental management activities;
6. Network operations expenses;
7. Charitable expenses;
8. Board, bureau or association fees; and
9. Payroll expenses.

(h) A detailed description of any cost-containment programs the Carrier is employing or will employ during the Rating Period to address Dental Care delivery costs and the realized past savings and projected savings from all such programs.

(i) An Actuarial Opinion and an actuarial memorandum developed and prepared by a qualified member of the American Academy of Actuaries that also includes the following:

1. Effective dates of the filed rates;
2. Whether the company intends to trend filed rates using a trend factor for future effective dates;
3. The trend factor and annual trend assumption, including the annual cost and utilization trend assumptions;
4. Trend exhibits supporting how trends were derived;
5. An exhibit that shows the most recent available experience for Massachusetts;

156.06: continued

6. A statement describing the rating factors and method used to calculate Individual, Employer Group, and Group Association premiums;
7. If a Carrier uses prior experience in developing premiums, a description of how the Carrier develops Group Association or Employer Group premiums;
8. A description of how the proposed Base Rates were developed, including experience used, trend assumptions used, and any other adjustments used; and
9. The average rate increase resulting from the proposed rates.

(j) A rate manual and demonstration of the used manual to calculate a sample premium rate.

(k) A description of the products for which the rates are being proposed, including a summary of benefits as well as the ranges of cost-sharing elements (the ranges of deductibles, coinsurance, copayments, benefit limits, out-of-pocket maximums), including any that differ by relevant service categories.

(l) Any other information requested by the Commissioner.

(3) Review of Rate Filings.

(a) All Base Rate changes and Rating Adjustment Factors are subject to disapproval if they do not meet the requirements of 211 CMR 156.00.

(b) A Carrier shall respond to any request for additional information by the Division within five business days of the date of the Division's request. Failure to respond to the Division's request within five business days may result in a delay of the Division's review of the filing and a delay in the proposed effective date of the filed rates.

(c) Every Carrier shall include a cover letter summarizing the content in 211 CMR 156.06(2)(d), (e) and (f). Base Rates will be presumptively disapproved as excessive if the rate filing does not meet the following standards:

1. Administrative Expense Standards. Base Rates will be presumptively disapproved if the filing's projected administrative expense loading component, not including taxes and assessments and Quality Improvement Activity expenses, increases by more than the Dental Services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted).
   a. The projected administrative expense loading component is the per-Member-per-month administrative expense described in 211 CMR 156.06(2)(d).
   b. The most recent calendar-year increase in the Dental Services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted) shall be calculated by dividing the index value for the December period preceding the date of the filing by the same index value from the December period on
2. Contribution to Surplus Standards. Base Rates will be presumptively disapproved as excessive if the rate filing's contribution-to-surplus loading component exceeds 1.9% of the total filed Base Rate. The contribution-to-surplus loading component shall represent the per-Member-per-month contribution-to-surplus amount submitted in 211 CMR 156.06(2)(e).
3. Projected Dental Loss Ratio Standards. Base Rates will be presumptively disapproved as excessive if the rate filing's projected aggregate dental loss ratio for all plans offered across all dental Markets is less than the Minimum Dental Loss Ratio.

(4) Presumptive Disapprovals Issued Pursuant to M.G.L. c. 176X, § 2(d).

(a) Rate filings may be presumptively disapproved by the Commissioner as described in 211 CMR 156.06(3).

(b) If a Carrier's filing is presumptively disapproved, the Commissioner shall notify the Carrier in writing within five business days of the annual rate filing submission stating the reason(s) for the presumptive disapproval.

(c) When initial Base Rates are presumptively disapproved, the associated Dental Benefit Plans may not be offered.

(d) Within ten days of receipt of the presumptive disapproval, the Carrier shall communicate to all employers and Individuals covered under a Dental Benefit Plan approved under M.G.L. c. 176X that the proposed rate change has been presumptively disapproved and will be subject to a public hearing at the Division.

156.06: continued

(e) In the event of a presumptive disapproval, the Carrier shall comply with the following procedures:

1. the Carrier shall not quote, issue, make effective, deliver, or renew Dental Benefit Plans in the Commonwealth using disapproved Base Rates. The Carrier shall quote, issue, make effective, deliver, or renew all Dental Benefit Plans using Base Rates in effect 12 months prior to the proposed effective date of the presumptively disapproved Base Rates. In recalculating premiums, the Carrier must apply the Rating Adjustment Factors in effect 12 months prior to the proposed effective date of the presumptively disapproved Base Rates;

2. the Carrier shall recalculate applicable rates for all affected Dental Benefit Plans and shall issue rate quotes and make all Dental Benefit Plans available through all distribution channels, but in no event more than ten calendar days after the Carrier's receipt of the presumptive disapproval; and

3. the Carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected Individuals and groups.

(f) With respect to the hearing for the presumptive disapproval:

1. the public hearing shall be scheduled within 15 calendar days of the submission of a complete rate filing; and

2. notice of the public hearing will be given to, or advertised in, newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford, and Lowell and posted to the Division's website.

3. The purpose of the public hearing will be to provide the Carrier with the opportunity to rebut the reasons for the presumptive disapproval. For purposes of 211 CMR 156.06(5)(f) the administrative record to be considered at the public hearing will be limited to the materials and information included in the Carrier's presumptively disapproved rate filing submitted pursuant to 211 CMR 156.06.

(5) Disapprovals Issued Pursuant to M.G.L. c. 176X, § 2(c).

(a) Rate filings also shall be disapproved by the Commissioner if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate, or unfairly discriminatory, or do not otherwise comply with the requirements of M.G.L. c. 176X or 211 CMR 156.00.

(b) New Rating Adjustment Factors or changes to previously allowed Rating Adjustment Factors shall be disapproved by the Commissioner if found to be discriminatory or not actuarially sound.

(c) New Dental Benefit Plans whose initial Base Rates are disapproved may not be offered.

(d) If the Commissioner disapproves a Carrier's proposed Base Rate(s), proposed new Rating Adjustment Factors, or proposed changes to previously allowed Rating Adjustment Factor(s), the Commissioner shall notify the Carrier and state the reason(s) for the disapproval, including whether the disapproval is presumptive. Unless otherwise determined by the Commissioner, if the Commissioner disapproves a Carrier's proposed Base Rate(s) or proposed changes to Rating Adjustment Factor(s), the Commissioner shall notify the Carrier in writing no later than August 15th of the year preceding the rates' proposed effective date, stating the reason(s) for the disapproval.

(e) In the event of a disapproval, the Carrier shall comply with the following procedures:

1. the Carrier shall not quote, issue, make effective, deliver or renew Dental Benefit Plans in the Commonwealth using disapproved Base Rates and the Carrier shall quote, issue, make effective, deliver, or renew all Dental Benefit Plans using Base Rates and Rating Adjustment Factors as in effect 12 months prior to the proposed effective date of the disapproved Base Rates;

2. the Carrier shall recalculate applicable rates for all affected Dental Benefit Plans and shall issue rate quotes and make all Dental Benefit Plans available through all distribution channels, including Intermediaries, the Connector, licensed insurance producers and the Carrier's website, but in no event more than ten calendar days after the Carrier's receipt of the disapproval; and

3. the Carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected Individuals and groups.

(f) The Commissioner retains the right to disapprove a rate filing for reasons other than those identified upon review of the rate filing.

156.06: continued

(g) Hearings on disapprovals issued pursuant to M.G.L. c. 176X, § (2)(c):
1. within ten days of receipt of the disapproval, the Carrier may request a hearing on the disapproval;
2. the Division shall schedule a hearing within 15 calendar days of receipt of the Carrier's request;
3. the purpose of the hearing will be to consider whether the disapproval is supported by substantial evidence and not based upon an error of law; and
4. The Commissioner shall issue a written decision either affirming or rejecting the disapproval within 30 days after the conclusion of the hearing.

(6) Appeals. Any final order, decree, or judgment of the Massachusetts Superior Court or appellate court modifying, amending, annulling, or reversing a decision of the Commissioner disapproving a rate filing, and any further decision of the Commissioner pursuant to such an order, decree, or judgment that affects the overall rate not disapproved shall be effective as ordered.

(7) Maintaining Records. Every Carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, in accordance with sound actuarial principles, and in compliance with the provisions of 211 CMR 156.00.

(8) Methodology for Calculating and Reporting Refund, Rebate or Credit Calculations.
(a) Unless otherwise determined by the Commissioner, for the purposes of M.G.L. c. 176X, § 2(d), Carriers are to calculate and submit a rebate calculation form as designated by the Commissioner each calendar year by July 31st for the previous calendar year.
(b) If the calculation illustrates that a refund or rebate is warranted, the Carrier shall submit a detailed plan for the Commissioner's approval that will provide a detailed description of the manner in which the Carrier will refund the excess premium to those Individuals or employers who were covered during the prior calendar year, or an explanation of the reasons that the Carrier proposes not to make a refund or rebate. The amount of the rebate will be based on each Individual's or Employer Group's relative share of the premiums that were paid to the Carrier during the prior calendar year.
(c) If the calculation illustrates that a refund or rebate is warranted, a Carrier shall communicate within 30 days to all Individuals and Employer Groups that were covered under Dental Benefit Plans during the relevant 12-month calendar year that such Individuals and Employer Groups qualify for a refund, which may take the form of either a refund on the premium for the applicable 12-month period, or if the Individual or Employer Group is still covered by the Carrier, a credit on the premium for the subsequent 12-month period.
(d) The basis for all refunds issued shall equal the amount of a Carrier's earned premium that exceeds the amount necessary to achieve the Minimum Dental Loss Ratio, as reported to the Commissioner. The Commissioner may authorize a waiver or adjustment of the refund requirement if the Commissioner determines premium credits are not feasible and that issuing such refunds would result in Financial Impairment for the Carrier, or if the Commissioner determines that such refunds are *de minimus* because the cost of distributing any refund exceeds the value of the refund itself. The aggregate of any *de minimus* amount not refunded shall be used to reduce overall premiums.
(e) Refunds shall be paid annually by August 30th, or another date as determined by the Commissioner, following the calendar year of the rebate calculation.
(f) Carriers who issue refunds shall keep records of all refunds made to affected Individuals and groups for inspection by the Division.
(g) No Individual or Employer Group may assign its or their rights to such premium adjustments to another person or entity.
(h) If a Carrier fails to make refunds, rebates, or premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits as deemed necessary.

156.07: Annual Comprehensive Financial Statement

On or before March 31st, the Division will collect reports that contain at least the following information about a Carrier's insured dental business in a format specified by the Commissioner. Each Carrier shall submit a detailed report on a form approved by the Commissioner of the insured dental business costs incurred by the Carrier as of December 31st of the prior calendar year.

(1) Market group size, including:
(a) Individual;
(b) Small Groups of one to five, six to ten, 11 to 25, and 26 to 50; and
(c) Large Groups of 51 to 100, 101 to 500, 501 to 1000, and greater than 1000.

(2) Lines of dental business, including:
(a) Non-network Dental Benefit Plans issued by an insurer licensed under M.G.L. c. 175;
(b) Non-network Dental Benefit Plans issued by a nonprofit hospital service corporation under M.G.L. c. 176A or by a nonprofit hospital service corporation under M.G.L. c. 176B or by a dental service corporation under M.G.L. c. 176E;
(c) Dental Benefit Plans that include a preferred provider arrangement issued under M.G.L. c. 176I;
(d) Dental Benefit Plans that only cover Dental Care provided by a closed network of providers without out-of-network benefits; and
(e) Dental Benefit Plans issued through the Group Insurance Commission under M.G.L. c. 32A.

(3) The Annual Comprehensive Financial Statement shall report the following information for each Market group size defined in 211 CMR 156.07(1) and each line of business defined in 211 CMR 156.07(2):
(a) Enrollment Information.
1. Number of distinct Employer Groups covered on December 31st.
2. Number of subscriber Members covered including:
a. Number of subscriber Members covered on December 31st;
b. Number of subscriber Member months covered in prior calendar year; and
c. Average number of monthly subscriber Members for prior calendar year.
3. Number of total subscriber and dependent lives covered including:
a. Number of total subscriber and dependent Members on December 31st;
b. Number of total subscriber and dependent Member months covered in the prior calendar year; and
c. Average number of monthly subscriber and dependent covered Members in the prior calendar year.
(b) Income Statement Information.
1. Premiums, including earned premiums (premium earned during the calendar year) and net earned premiums (direct premiums earned, plus premium assumed, and less reinsurance ceded).
2. Incurred Claims, including direct claims paid during the calendar year on services rendered during the calendar year, unpaid claims reserves on service rendered or claims incurred during the calendar year, changes in contract reserves, the claims-related portion of reserves for contingent benefits and lawsuits, and experience rating refunds paid or received and reserves for experience rating refunds with negative adjustment for Dental Care receivables and for reinsurance recoverables.
3. Actual Dental Loss Ratio, as defined in accordance with 211 CMR 156.03.
4. Investment gains and losses:
a. Investment income, including that part of a Carrier’s income that stems from the interest and dividends earned on the stocks and bonds it owns or the return on any other invested funds; and
b. Net Realized capital gains and losses, including the difference between the amount received from the sale or disposal of an asset and its carrying value.
5. Financial administration expenses, including all costs associated with underwriting, auditing, actuarial, financial analysis, investment-related expenses (not included elsewhere), treasury, reinsurance, and outside benefit consultants.

156.07: continued

6. Marketing and sales expenses:
   a. Billing and Member enrollment, including all costs associated with group and individual billing, Member enrollment, premium collection, and reconciliation functions;
   b. Customer services and Member relations, including all costs associated with individual, group or provider support relating to membership, enrollment, grievance resolution, specialized phone services and equipment, consumer services, and consumer information;
   c. Product management, marketing and sales, including all costs associated with the management and marketing of current products, including product promotion and advertising, marketing materials, changes or additions to current products, sales, pricing, and enrollee education regarding coverage prior to the sale; and
   d. Product Development, including all costs associated with product design and development for new products not currently offered, major systems development associated with the new products, and integrated system network development.

7. Distribution expenses, including all costs associated with the distribution and sale of products, including commissions, insurance producer and benefit consultant fees, intermediary fees, commission processing, and account reporting to insurance producers.

8. Claims operations expenses, including all costs associated with claims adjudication and adjustment of claims, appeals, claims settlement, coordination of benefits processing, maintenance of the claims system, printing of claims forms, claim audit function, electronic data interchange expenses associated with claims processing, and fraud investigation.

9. Dental administration expenses:
   a. Quality assurance and cost containment, including all costs associated with dental and disease management and wellness initiatives (other than for education), Dental Care quality assurance, appeals, case management, network access fees, fraud detection and prevention, utilization review, practice protocol development, peer review, outcomes analysis related to existing products, nurse triage, dental management, and other Dental Care evaluation activities;
   b. Wellness and dental education, including all costs associated with wellness and dental promotion, disease prevention, Member education and materials, and education and outreach services; and
   c. Dental research, including all costs associated with outcomes research, dental research programs and development of new dental management programs not currently offered, major systems development, and integrated system network development.

10. Network operational expenses, including all costs associated with provider contracting negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, administration of provider capitation and settlements, dental policy procedures, dentist relations, dental policy procedures, network access fees, and credentialing.

11. Charitable expenses, including all costs associated with contributions to foundations, charities that are not related to the company business enterprises, and community benefits.

12. Taxes, Assessments and Fines Paid to Federal, State or Local Government:
   a. Taxes (premium, real estate, other non-payroll) paid, including all costs associated with state premium taxes, state and local insurance taxes, federal taxes, except taxes on capital gains, state income tax, state sales tax, and other sales taxes not included with the cost of goods purchased;
   b. Assessments, fees and other amounts paid to government agencies, including all assessments, fees or other amounts paid to state or local government, but excluding any taxes or fines or penalties paid to any government agency; and
   c. Fines and penalties paid to government agencies, including all costs associated with penalties and fines paid to government agencies.

156.07: continued

13. General Administration:

a. Payroll administration expenses and payroll taxes, including all costs associated with salaries, benefits, and payroll taxes (not allocated elsewhere);

b. Real estate expenses, including all costs associated with company building and other taxes and expenses of owned real estate, excluding home office employee expenses, and rent (not allocated elsewhere) and insurance on real estate;

c. Regulatory compliance and government relations, including all costs associated with Federal and State reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, preparation and filing of financial, utilization, statistical, and quality reports, and administration of government programs;

d. Board, bureau and association fees, including all board of directors, bureau, and association fees paid or expensed during the calendar year;

e. Other administration, including all costs associated with information technology, senior management, outsourcing (not allocated elsewhere), insurance except on real estate, equipment rental, travel (not allocated elsewhere), certification and accreditation fees, legal fees and expenses before administrative and legal bodies, and other general administrative expenses;

f. Reimbursement from uninsured plans, representing a negative adjustment that would include all revenue receipts from uninsured plans (including excess pharmaceutical rebates and administrative fees net of expenses) and reimbursements from fiscal intermediaries (including administrative fees net of expenses from the government); and

g. Number of employees on the Carrier's payroll on December 31st of the preceding year, including the number of full-time employees whose normal work week is 30 or more hours, but not including any employee who works on a part-time, temporary, or substitute basis.

14. Detailed miscellaneous expenses including, but not limited to, all collection and bank service charges, printing and office supplies not allocated elsewhere, postage, and telephone not allocated elsewhere.

15. Capital Expenses and Depreciation:

a. Depreciation, including all costs associated with depreciation for electronic data processing, equipment, software, and occupancy;

b. Capital acquisitions, including all expenditures for the acquisition of capital assets, including lease payments that were paid or incurred during the calendar year;

c. Capital costs on behalf of a clinic, including all expenditures for capital and lease payments incurred or paid during the calendar year on behalf of a clinic (or part of a partnership, joint venture, integration, or affiliation agreement); and

d. Other capital costs, including expenditures for other costs that are directly associated with the incurring of capital costs, such as legal or administrative costs, incurred or paid during the calendar year.

16. Net income, which equals direct premiums earned, less direct claims incurred, less expenses, plus investment gains and losses.

(c) Balance Sheet

1. Accumulated surplus, including common stock, preferred stock, gross paid in and contributed surplus, surplus notes, unassigned funds, and other capital or surplus items.

2. Accumulated reserves, including all reserves, including claim reserves, premium reserves, and contract reserves.

3. Risk based capital ratio in accordance with 211 CMR 25.00: *Risk-based Capital (RBC) for Health Organizations*.

(4) The company will provide a detailed description of any method of allocation employed to attribute expenses that are not directly assigned to a group size or line of business, and the expenses, group sizes, and lines of business to which the allocation is applied.

(5) If a Carrier is unable to provide any of the required information in its Annual Comprehensive Financial Statement, the Carrier shall provide a detailed explanation, within the Annual Comprehensive Financial Statement, of the reason(s) that such required information is not available.

156.07: continued

(6) A Carrier that fails to submit its Annual Comprehensive Financial Statement to the Division on or before April 1st of each year shall be assessed a late penalty by the Commissioner not to exceed $100 per day.

(7) The Division shall make public all of the information collected under this section. The Division shall issue an annual summary report of the annual comprehensive financial statements to the Joint Committee on Financial Services, the Joint Committee on Health Care Financing, and the House and Senate Committees on Ways and Means. The information shall be exchanged with the Center for Health Information and Analysis for use under M.G.L. c. 12C, § 10. The Division shall, from time to time, require Carriers to submit the underlying data used in their calculations for audit.

156.08: Audit of Annual Comprehensive Financial Statement

(1) The Commissioner may, in his or her discretion, require that a Carrier make available the underlying data used in its calculations for its Annual Comprehensive Financial Statement, if applicable, for audit by Division staff or outside consultants or Advisors of the Division.

(2) Any and all fees and costs for the Division's audit of the Carrier's Annual Comprehensive Financial Statement shall be borne by the subject Carrier.

156.09: Public Hearing on Carrier's Financial Condition

(1) If, in any year, a Carrier reports in its Annual Comprehensive Financial Statement that its Risk-based Capital ratio on a combined entity basis exceeds 700%, then the Commissioner, or a designated Presiding Officer, shall hold a public hearing to examine the Carrier's overall financial condition and the Carrier's continued need for additional surplus.

(2) The public hearing shall be held within 60 days of the date of the Carrier's filing of its fully completed Annual Comprehensive Financial Statement.

(3) At the public hearing, the Carrier shall submit testimony on its overall financial condition and its 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 on dental Quality Improvement Activities, patient safety, or dental cost-containment activities not conducted in previous years.

(4) The Commissioner shall issue written notice of the public hearing to the subject Carrier no less than 30 days prior to the public hearing.

(5) The Carrier shall arrange for newspaper publication of the written notice of the public hearing in a newspaper or newspapers designated by the Commissioner. Such notice shall be published no less than 21 days prior to the public hearing.

(6) No later than 15 days prior to the public hearing, the Carrier shall submit a filing to the Division containing:

(a) The title and docket number of the proceeding and the complete name and address of the Carrier submitting the filing;

(b) A summary containing a description of the contents of the filing;

(c) A list of the names and occupations of all persons who will present oral testimony, statements, or comments on behalf of the Carrier at the public hearing; and

(d) Any other information required by the Commissioner or the Presiding Officer.

(7) The Carrier's filing shall describe the Carrier's overall financial condition and any reasons why the Carrier believes the additional surplus is needed. The filing shall also describe 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 on Dental Care Quality Improvement Activities, patient safety, or dental cost containment activities not conducted in previous years.

156.09: continued

(8) Duties of the Presiding Officer. The Presiding Officer shall conduct the public hearing and take appropriate action to ensure the orderly conduct of the public hearing. Testimony may be taken under oath or affirmation, at the discretion of the Presiding Officer.

(9) Transcript. The Carrier shall arrange that any public hearing be officially recorded by a stenographer. The full cost of the stenographer's fees, along with the cost of providing two copies of the written transcript of the public hearing to the Division, shall be paid by the Carrier.

(10) The Commissioner shall review the testimony from the public hearing and issue a final report on the public hearing.

156.10: Severability

If any section or portion of a section of 211 CMR 156.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 156.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 156.00: M.G.L. c. 176X.