Alliance of Independent Dentists
MASSACHUSETTS

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The Alliance of Independent Dentists (AID) has reviewed the many submissions that stakeholders have made during Comment Sessions 1-4 of the subject heading regulations.

AID has taken the position that it fully agrees with the written and oral comments provided by the Committee on Dental Insurance Quality (CDIQ), its chairman Dr. Mouhab Rizkallah, and its attorney Matthew Perry.

OF PARTICULAR IMPORTANCE TO AID ARE THE FOLLOWING 2 POINTS:

1. **THE MLR NUMERATOR DEFINITION**: (Incurred Claims + Quality Improvement Activities)

- **INCURRED CLAIMS:** As described by CDIQ, incurred claims must only include payments ultimately received by the provider for dental services. This means that payments *meant* for the provider and not *received* by the provider (such as payments made directly to patients that do not reach the provider) are not counted in the numerator. Fraudulent losses of this type are part of an insurance company's fraud administration expense.

- **QUALITY IMPROVEMENT ACTIVITIES (QIA):** As described by CDIQ, AID does not believe QIA's should be allowed in the MLR numerator. However, if the DOI determines it will allow QIA's, AID agrees with the CDIQ limitations on QIA (see below).
    - **QIAs shall:**
        - Be available only ***through*** providers.
        - Be equitable to all patients.
        - Require clinical expertise.
        - Increase clinical wellness and promotion of health activities.
        - Produce clinical outcomes that can be objectively measured and can produce verifiable results.

    - Be 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).
    - Be supported by evidence-based medicine, best clinical practices, or criteria issued by professional medical associations.
- **QIAs shall not:**
    - Have any overlap with administrative expense items specified under Section 2(b)(i)-(x).
    - Have any marketing component that displays the name of the insurer.
    - Be paid by the insurer to **any** affiliate of the insurer in any way, either directly or indirectly.
    - Be greater than 1% of premium revenue.

2. **ADMINISTRATIVE EXPENSE CATEGORIES**:
    - **SECTION 2b** should be closely followed for categorization of administrative expenses (not the Federal ACA categorization).

    - **SECTION 2b** specifically deems the following as administrative expenses:
        i. Financial Administration Expenses
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        v. Medical Administration Expenses (such as disease management, care management, utilization review & medical management activities).
        vi. Network operations expenses
        vii. charitable expenses
        viii. board, bureau, or association fees
        ix. state and federal tax expenses (including assessments)
        x. payroll expenses

Thank you for reviewing our submission.

Dr. Jill Tanzi, President
Alliance of Independent Dentists, Massachusetts

Dr. Kristine Grazioso, Vice-President
Alliance of Independent Dentists, Massachusetts

March 14, 2023

Kevin Beagan, Deputy Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston MA 02118-6200

Dear Deputy Commissioner Beagan:

On behalf of the Massachusetts Association of Health Plans, which represents 14 health plans and two behavioral health organizations that provide coverage to nearly 3 million Massachusetts residents, we appreciate the opportunity to submit written comments to the Division of Insurance (Division) relative to the implementation of M.G.L. c. 176X, statutory changes to dental insurance in Massachusetts enacted via ballot question. MAHP and our member plans continue to have concerns that policies in the new law could threaten the stability of our state's robust dental market if not implemented in a thoughtful and deliberate way.

As your office works to draft regulations incorporating novel statutory language into the Division's existing oversight framework, we respectfully ask that close consideration be given to the complexity of the new law. Extensive provisions that are unprecedented in the dental market will require significant administrative and operational work by carriers to implement new processes and procedures. Moreover, the language does not recognize the unique characteristics of our state's dental marketplace and instead creates redundancy, contradictions, and ambiguity throughout. This complexity is evidenced by the scheduling of numerous listening sessions to consider detailed questions posed by the Division, reflecting the complicated task ahead to interpret vague terms and directions. While the text of the new law mirrors language in existing state statutes applicable to medical carriers in Massachusetts, the development of regulations will require the reconciliation of conflicting obligations. Therefore, is its essential that the regulations issued be clear and unambiguous to ensure that new processes are conducted in a consistent fashion that does not unnecessarily create additional regulatory barriers that adversely impact access to dental benefits or drive up the cost of coverage for families and small businesses.

Specifically, the Division will need to clarify which carriers are subject to the provisions of the new law and ensure that the requirements contemplated under the law are not duplicative, or preempted by ERISA for self-insured plans. The Division will also need to carefully develop definitions for terms of the law that are not clear. We support leveraging existing regulations where helpful to avoid complications; however, M.G.L. 176X is silent on a definition of dental loss ratio and does not specify a particular methodology to be utilized by carriers. The Division will also need to set clear expectations for carriers around the data collection and reporting requirements and the associated timelines for submissions and review by the Division. We support the development of filing templates to assist carriers in complying with the new law, based on current materials circulated by the Division. MAHP

is currently working to draft specific recommendations on these issues for submission to the Division in the near future.

Dental insurance is fundamentally different from medical insurance, both in product design and price. Carriers manage overall costs by paying for a greater share of preventive services to encourage regular visits that can reduce the need for more costly treatments in the future. Higher cost sharing for restorative procedures keeps dental premiums low and affordable. Because the covered services and cost structure of these products are different from major medical products, they cannot be treated in the same manner. The Affordable Care Act (ACA) expressly excludes dental products from Medical Loss Ratio (MLR) requirements for this very reason -- stand-alone dental plans are considered to be Excepted Benefit Plans and therefore exempt from many of the more burdensome constraints of the ACA.

The premium amounts for dental plans are much lower than major medical premiums, but the fixed costs are similar. These complex requirements will require plans to dedicate additional resources, time, and premium dollars to administrative duties to meet the requirements. But there is little room for dental carriers to reduce expenses associated with claims processing, call centers, provider network development, and consumer protections including anti-fraud efforts, timely access standards, and grievance procedures, without affecting customer service levels. Since the administration of benefits and regulatory requirements are not variable costs, dental plans could be forced to increase premiums in order to meet these requirements, which is not in the consumer's best interests. It is important to consider that any increase in premiums may result in individuals, especially lower-income adults, foregoing coverage and dental care altogether. Those without coverage are far less likely to get the preventive and diagnostic care they need to head off more costly and painful dental conditions later.

We appreciate the Division's commitment to developing regulations that maximize the value to consumers and do not produce unintended consequences such as increased premiums, reduced access to dental benefits, or limited employer and consumer options for affordable dental coverage in the Commonwealth. We look forward to working closely with you as you draft regulations and thank you in advance for your consideration.

Sincerely,

Elizabeth Murphy

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The Alpha Omega Dental Society, Boston Chapter has reviewed the many submissions that stakeholders have made during Comment Sessions 1-4 of the subject heading regulations.

Alpha Omega Dental Society, Boston Chapter has taken the position that it fully agrees with the written and oral comments provided by the Committee on Dental Insurance Quality (CDIQ), its chairman Dr. Mouhab Rizkallah, and its attorney Matthew Perry.

OF PARTICULAR IMPORTANCE TO AID ARE THE FOLLOWING 2 POINTS:

1. **THE MLR NUMERATOR DEFINITION**: (Incurred Claims + Quality Improvement Activities)

- **INCURRED CLAIMS:** As described by CDIQ, Incurred claims must only include payments ultimately received by the provider for dental services. This means that payments *meant* for the provider and not *received* by the provider (such as payments made directly to patients that do not reach the provider) are not counted in the numerator. Fraudulent losses of this type are part of an insurance company's fraud administration expense.

- **QUALITY IMPROVEMENT ACTIVITIES (QIA):** We agree with CDIQ that QIA's should not be allowed in the MLR numerator. However, if the DOI determines it will allow QIA's, we agree with the CDIQ's proposed QIA limitations (below).
    - **QIAs shall:**
        - Be available only ***through*** providers.
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        - Be supported by evidence-based medicine, best clinical practices, or criteria issued by professional medical associations.
    - **QIAs shall not:**
        - Have any overlap with administrative expense items specified under Section 2(b)(i)-(x).
        - Have any marketing component that displays the name of the insurer.

- Be paid by the insurer to **any** affiliate of the insurer in any way, either directly or indirectly.
- Be greater than 1% of premium revenue.

2. **ADMINISTRATIVE EXPENSE CATEGORIES**:
   - **SECTION 2b** should be closely followed for categorization of administrative expenses (not the Federal ACA categorization).

   - **SECTION 2b** specifically deems the following as administrative expenses:
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     x. payroll expenses

Thank you for reviewing our submission.

Dr. Matthew Lann, President
Alpha Omega Dental Society, Boston Chapter

New England Dental Society

Howard Pactovis DMD, Secretary-Treasurer
5 Wimbledon Court
Ipswich, MA, 01938

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The New England Dental Society has reviewed the many submissions that stakeholders have made during Comment Sessions 1-4 of the subject heading regulations.

The New England Dental Society has taken the position that it fully agrees with the written andoral comments provided by the Committee on Dental Insurance Quality (CDIQ), its chairman Dr. Mouhab Rizkallah, and its attorney Matthew Perry.

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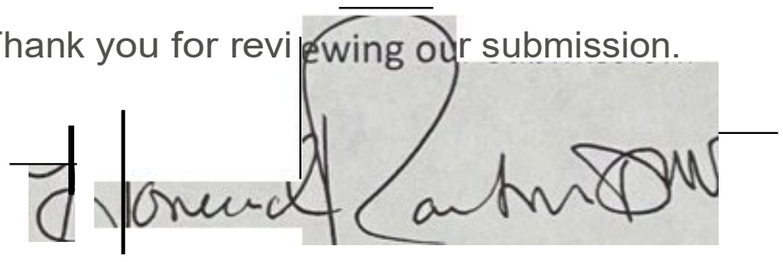

Dr. Howard Pactovis, Secretary-Treasurer
New England Dental Society

Kevin Beagan, Deputy Commissioner

Rebecca Butler, Counsel to the Commissioner

Massachusetts Division of Insurance

1000 Washington Street, #810

Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The Metropolitan District Dental Society has reviewed the many submissions that stakeholders have made during Comment Sessions 1-4 of the subject heading regulations.

Metropolitan District Dental Society has taken the position that it fully agrees with the written and oral comments provided by the Committee on Dental Insurance Quality (CDIQ), its chairman Dr. Mouhab Rizkallah, and its attorney Matthew Perry.

OF PARTICULAR IMPORTANCE TO AID ARE THE FOLLOWING 2 POINTS:

1. **THE MLR NUMERATOR DEFINITION**: (Incurred Claims + Quality Improvement Activities)

- **INCURRED CLAIMS:** As described by CDIQ, Incurred claims must only include payments ultimately received by the provider for dental services. This means that payments *meant* for the provider and not *received* by the provider (such as payments made directly to patients that do not reach the provider) are not counted in the numerator. Fraudulent losses of this type are part of an insurance company's fraud administration expense.

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Thank you for reviewing our submission.

Dr. Ken Marsh

Dr. Ken Marsh, Secretary

Metropolitan District Dental Society

Kevin Beagan, Deputy Commissioner

Rebecca Butler, Counsel to the Commissioner

Massachusetts Division of Insurance

1000 Washington Street, #810

Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The Massachusetts Society of Oral and Maxillofacial Surgeons (MSOMS) has reviewed the many submissions that stakeholders have made during Comment Sessions 1-4 of the subject heading regulations.

MSOMS has taken the position that it fully agrees with the written and oral comments provided by the Committee on Dental Insurance Quality (CDIQ), its chairman Dr. Mouhab Rizkallah, and its attorney Matthew Perry.

OF PARTICULAR IMPORTANCE TO AID ARE THE FOLLOWING 2 POINTS:

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Thank you for reviewing our submission.

Dr. Robert Memory, President

Massachusetts Society of Oral and Maxillofacial Surgeons

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287 of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The Massachusetts Association of Orthodontists (MAO) has taken the position that it supports the written comments provided by the Committee on Dental Insurance Quality (CDIQ).

OF PARTICULAR IMPORTANCE TO AIP ARE THE FOLLOWING 2 POINTS;

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Thank you for reviewing our submission.

E. Elon Joffre, DMD, MPH
President
Massachusetts Association of Orthodontists

BLISH & CAVANAGH LLP
COUNSELLORS AT LAW

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Mary Cavanagh Dunn
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Robert J. Cavanagh, Jr.
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John H. Blish
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March 31, 2023

Kevin Beagan
Deputy Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118
kevin.beagan@mass.gov

Rebecca Butler
Counsel to The Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118
Rebecca.butler@mass.gov

Re: Altus Dental Insurance Company, Inc.
Comments With Respect To Final Informative Session (Session #5);
Chapter 287 Of The Acts Of 2022 (An Act To Implement
Medical Loss Ratios For Dental Benefit Plans); M.G.L. c. 176X

Dear Mr. Beagan and Ms. Butler:

In behalf of Altus Dental Insurance Company ("Altus"), and following up on the (Fifth) Informative Session conducted on March 15, 2023, we respectfully submit the following comments with respect to written submissions made by other parties. These comments supplement the sets of Comments Altus has previously filed with respect to each of Sessions 1, 2, 3 and 4 of the "Informative Session" process.

• Several of the submissions overstate – and thereby distort – the extent to which M.G.L. c. 176X binds the Commissioner in terms of the types of expenses listed in Section 2(b) that are required to be included in the actual **calculation** of the dental loss ratio, as opposed to only being **reporting** items. Section 2(b) specifically provides for **the Commissioner** to ultimately determine which of the categories of expenses listed in Section 2(b)(i) through (x) will factor into the actual **calculation** of the dental loss ratio.

• To our knowledge no other Medical Loss Ratio – and certainly no other Dental Loss Ratio – has ever been established as high as 83% without a litany of expenses – including premium taxes – being excluded from the ratio calculation methodology.

• M.G.L. c. 176X itself requires that the Commissioner, in his development of regulations under that law, "consult with other agencies of the Commonwealth and the federal government." When the Affordable Care Act ("ACA") was enacted, it required the NAIC to establish uniform definitions and standardized methodologies for calculating Medical Loss Ratios that have become an industry regulatory standard. Under that standard, "federal and state taxes, assessments and fees" (which, of course, carriers have no control over) – as well as medical incentive pool expenses and bonuses and costs related to improving health care quality and fraud reduction – are **not** included as administrative expenses. Certain of those expenses – most notably state and federal taxes – are excluded from administrative expenses in the annual loss ratio reporting filings Altus is already required to make with the Division on Mass Connector products.

• None of the comments included in the submissions by the dental community include any objection to taxes being excluded as an administrative expense.

• And, as Altus has previously noted, expenses that are not costs of the carrier at all should most certainly not be included as administrative expenses for purposes of the DLR calculation. For example, Altus' group customers very often hire independent-external professional consultants (or brokers) to assist them in making and coordinating benefit plan decisions with carriers. As a courtesy to the customer and consultant (or broker), the fees or commissions for that service are reflected on Altus' billings to the customer, but only on a pass-through basis. The money paid by the customer goes not to Altus, but to the group's retained consultant (or broker). It is not a debt or obligation or expense ("administrative"; "distribution", or otherwise) of Altus at all. Altus does not have or use brokers or consultants and does not incur expense with respect to any such services. The fees or commissions that these consultants charge are obligations of the customer – not Altus. They have no bearing on the value proposition that medical or dental loss ratios represent, *i.e.*, the proportion that payments for health care services bear in relation to the expenses and profits **the health plans experience** – not independent contractors that the customer hires at its own discretion and cost.

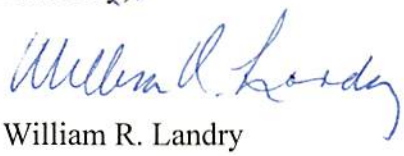
• We have previously demonstrated in very practical terms (in our letter dated January 30, 2023) how, with a dental loss ratio as high as 83% and both premium taxes and pass through external consultant/broker commissions and fees improperly being counted as "administrative expenses", there is not enough money left after claims payments for companies like Altus to operate the business. The only way we would be able to meet an 83% dental loss ratio would be to significantly increase claims payments, and correspondingly increase the premiums our customers are required to pay, further pushing the cost of dental insurance beyond the reach of consumers and employers. This is the very fear and expectation that Health Care For All ("HCFA") has registered in its comments on c. 176X. *The cost of dental care* is overarchingly the determinant of the cost of dental insurance.

• The dental community suggests that the "incurred claims" numerator of the dental loss ratio should include only payments to dental providers and not payments made directly to the patient/consumer or any other third party for dental services. There are multiple reasons why a payment would be made directly to a dental carrier's member rather than to a dentist. Reasons that have noting to do with "fraud". It is the members – not the dentists – that have been held out as the primary intended beneficiaries of the law. And it is the members – and/or their employers – that pay for the coverage, and who are to receive rebates resulting from the required ratio not being achieved. Respectfully if an expense is a payment for dental services, it belongs in the numerator of the dental loss ratio. It is most certainly not an "administrative expense" of the carrier.

• As is done now nationally under the ACA, incentive pool expenses and bonuses should also be included in the numerator as a claims expense.

Thank you for this opportunity for Altus to again comment on the regulatory implementation process with respect to c. 176X. Please do not hesitate to contact us in the event you have questions or desire additional information.

Sincerely,



William R. Landry

March 31, 2023

Mr. Kevin Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street, Boston, MA 02118

Re: Associated Industries of Massachusetts Comments on the Implementation of Chapter 287 of the Acts of 2022, *An Act to implement medical loss rations for dental benefit plans*

Deputy Commissioner Beagan:

On behalf of the Associated Industries of Massachusetts (AIM) and our over 3,500 cross-industry employer members, I write to thank you for the Division of Insurance (DOI) work to implement Chapter 287 of the Acts of 2022, and to offer AIM's comments and concerns on its implementation.

As the largest trade association in the state representing employers investing directly in their employee's health and wellbeing, our goal has remained to advocate for quality health care services that are equitable and accessible for Massachusetts residents and affordable for employers and employees alike. As such, our concerns with Chapter 287's ultimate implementation pertain to its likely effects on smaller dental carriers and the eventual repercussions on small employers.

As you know, a small dental carrier with fewer lines of insurance and lower premiums will not have the same flexibility in expense allocation to meet the 83% dental loss ratio as a larger medical/dental carrier that can more easily reallocate administrative expense. Smaller carriers will be less likely to meet the new target without increasing reimbursements and thereby raising premium costs ultimately borne by employers and patients. Effects on a smaller carriers' ability to remain in the Massachusetts market also translate to decreased consumer choice, impeding market competition and innovation. This again will lead to increased prices on consumer businesses without a reciprocal change in the quality of care or services.

Although we agree with voters' intention of ensuring funds are applied towards patient care enhancement, if the dental loss ratio is not administered intentionally, voters could see the opposite effect with respect to higher costs and less improvement in care. As such, AIM supports the recommendations submitted to your attention by the National Association of Benefits and Insurance Professionals Massachusetts chapter (NABIP-MA) to exempt costs that are not attributable to carriers from the loss ratio calculation, thereby complying with Chapter 287 and providing additional stability in the market for smaller carriers and, ultimately, small employers.

Thank you again for your diligence in collecting stakeholder feedback and thoughtfully approaching the task of implementing Chapter 287 as approved by Massachusetts voters last November. AIM appreciates the opportunity to share our perspectives with you directly. Should you require any further information or clarification, please do not hesitate to contact me at either (617)-488-8336 or vsangar@aimnet.org.

Sincerely,

Vasundhra Sangar
Vice President, Government Affairs
Associated Industries of Massachusetts (AIM)

March 31, 2023

Deputy Commissioner Kevin Beagan
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston MA. 02118

Rebecca Butler
Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA. 02118

Re: Massachusetts Dental Society-Response to Division of Insurance Information Sessions on Chapter 287 of the Acts of 2022 (An Act to Implement Medical Loss Ratios for Dental Benefit Plans); M.G.L. c. 176X

Deputy Commissioner Beagan and Attorney Butler,

Thank you for the opportunity to submit written comments to the Division of Insurance (hereafter, "DOI" or "the Division") regarding Chapter 287 of the Acts of 2022 (hereafter, "the Act"). The Association of Dental Support Organizations (hereafter, "ADSO") is a non-profit organization committed to providing support to its members, allowing affiliated dentists to focus on patients, expand access to quality dental care and improve the oral health of their communities.

By way of background regarding ADSO, Dental practices contract with Dental Support Organizations ("DSOs") to provide critical business management and support including non-clinical operations. The creation of DSOs have allowed dentists to maximize their practice with the support of professional office management. The DSO model enables dentists to focus on the patient while delivering excellent dental care. In Massachusetts, ADSO's members support 109 dental offices, comprised of hundreds of dentists and hygienists across the Commonwealth.

While Massachusetts voters made it clear at the ballot that they want more affordable, higher quality dental care, we recognize that the Division now faces the difficult challenge of crafting regulations that will make the voters' mandate a reality. Drawing on our members' daily experience treating patients as well as their frequent interaction with payers, ADSO respectfully submits the following comments for the Division's consideration, which we believe get to the heart of improving patient care in Massachusetts.

For the sake of brevity, and in order to stress the importance of these issues, ADSO would like to limit our written responses to just two "high level" points regarding one question offered by the Division as part of the Information Session process (Question 7 from Information Session #1, provided below). Based upon our members' experience in the field, we believe that the following two points are essential to effective new regulations for dental care.

7) Are there other items within the law that should be defined or clarified? There do not appear to be any definitions of the following terms which are used in the Section 2 of M.G.L. c. 176X

In order to create higher quality of care for patients while also increasing efficiencies for both payers and providers throughout the State, it is critical that the Division defines the "medical loss ratio" (alternatively referred to as a "dental loss ratio" in some written comments) in a manner that conforms to the following core principles.

(1) "Claims" or "claims incurred" should be defined as narrowly as possible.

Massachusetts voters sent a clear directive that carriers must spend more of every dollar on patient care and less on other costs. Defining "claims" in a narrow manner that is focused on patient care will go a long way towards achieving the will of the voters.

Although the specific details of this definition can be hashed out through the upcoming rulemaking process, we respectfully request that the Division adheres to the general principle of creating a narrow, patient-oriented definition of "claims" or "claims incurred" when drafting regulations.

(2) Any Quality Improvement Activities (QIA's) Should Be Exclusively Focused on Improving Patient Care

In written comments, other stakeholders have opined on the use of Quality Improvement Activities (hereafter, "QIA's") as part of the "numerator" for the Medical Loss Ratio. ADSO believes that QIA's could be a successful tool for improving patient care and modernizing the dental industry in Massachusetts, but only if the term "QIA" is properly defined.

In order to create QIA's that achieve the voters' goals, QIA's should only be included in the regulations if they are limited to:

(a) quality incentives;
(b) provided to dentists;
(c) for meeting specific quality benchmarks; and
(d) based on clinical standards established by evidence-based dentistry.

Using the four points listed above as "guard rails," the ADSO believes that QIA's could be used to help improve the quality of dental care in Massachusetts without creating a potential loophole that could be used to contradict the very purpose of the Act. A definition of QIA's that includes these four guard rails would give carriers the flexibility needed to spur innovation and high quality care while also ensuring that any money that is spent on "quality improvement" truly does what it is meant to do – improve the quality of patient care.

The ADSO greatly appreciates the opportunity to provide comment. As discussed above, we have tried to limit our comments to the two issues, described above, because we think they are essential to creating greater access, affordability, and quality of care for patients in Massachusetts.

If you have any questions or if there is any additional information that we can provide to the Division, please do not hesitate to contact us.

Sincerely,

Andrew Smith
Executive Director

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March 21, 2023

Deputy Commissioner Kevin Beagan
Massachusetts Division of Insurance
100 Washington St
Suite #810
Boston, MA 02118

Re: Chapter 287 of the Acts of 2022

The National Federation of Independent Business (NFIB) is a non-profit, non-partisan organization, and our state's largest small business advocacy group. In Massachusetts, NFIB represents thousands of small and independent business owners involved in all types of industry, including manufacturing, retail, wholesale, service, and agriculture.

Small businesses are already grappling with the high cost of health insurance, steps must be taken to ensure the implementation of Chapter 287 of the Acts of 2022 does not lead to increased dental insurance costs too. That would mean the need to avoid dramatic premium price spikes, deter service disruptions, and guarantee small employers do not experience fewer dental insurance options. The Division of Insurance should take precautions to prevent any dental insurance market instability, resulting from this new law, for Massachusetts employers and their workers.

Thank you for attention to this matter.

Sincerely,

Christopher R. Carlozzi
NFIB State Director

March 31, 2023

Hon. Gary D. Anderson
Commissioner of Insurance
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118

Re: Implementation of MGL c. 176X

Dear Commissioner Anderson,

Thank you for the opportunity to submit comments regarding the proposed implementation of MGL c. 176X relative to the new reporting requirements and establishment of a dental loss ratio ("DLR") in Massachusetts. Delta Dental of Massachusetts ("Delta Dental") recognizes the importance of a transparent, accessible, and affordable oral health care system. Oral health care is healthcare, and in adopting this ballot question, Massachusetts voters set clear expectations that this new law would provide dental patients with improved access to more valuable, affordable, quality dental care. We believe the will of the voters should be followed and these principles should serve as the North Star in implementing this law.

As a matter of policy, DLR is a novel concept. Although dental care is excluded from the Affordable Care Act (the "ACA"), the ACA's medical loss ratio ("MLR") regulatory scheme provides a framework the Division of Insurance (the "Division") can refer to for implementation, including the utilization of quality initiatives, that will provide a guarantee of improved benefits to dental patients, continued modernization and potentially higher reimbursements for providers. Given the novelty of DLR and the complexity of the dental market, we ask that the Division take this opportunity for diligent review of the industry and best practices to ensure these regulations are sufficiently tailored to the dental industry with parity across all carriers in the space. While there are parallels to be drawn from the implementation of MLR, there are also important differences to consider. Unlike medical's curative model, dental's focus on preventive care creates a more predictable system with higher frequency of claims with lower severity - most dental claims cost much less than medical illness or injury. This savings is passed on to the consumer in the form of lower premiums, averaging just $35 a month in Massachusetts. Notably, when a required MLR was adopted at the state level, and subsequently via the ACA, it was done among a series of other reforms designed to ensure access, reduce costs, and improve the quality of care. Though this broader scheme of reforms is absent in the new legislation, the Division can use its existing authority to promulgate a set of regulations that incentivize innovation and benefits providers, patients, carriers, and the market.

In line with the MLR model, including quality improvements in the regulation will provide patients with assurances on the value of dental care in the Commonwealth. Dental quality initiatives in DLR will incentivize equitable access to oral health, preventative care, disease management and the adoption of technologies that will enhance the dental experience for patients and ensure providers are not left behind as advancements occur. Adopting quality initiatives not only assures that patients benefit, but also permits flexibility in a modernizing insurance space as it moves toward a digitally-enabled, data-driven, and value-based system which improves outcomes, increases reimbursement and ensures access to quality care for patients.

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In promulgating regulations, the Division should use its discretion, where applicable, to ensure that the existing, stable, healthy market is maintained and that the DLR requirements improve quality, value and access to dental care for patients. Massachusetts has an opportunity to align the interests of all stakeholders in implementing these regulations by fostering innovation and encouraging advancement and modernization in the dental care space. Delta Dental appreciates the opportunity provided by the Division to participate in the recent Information Sessions and to review materials submitted by various interested parties as the Division is developing its regulations. We echo and support many of the specific statements raised by our peers at MAHP, and other carriers and trade groups, related to definitions, products, rate filings and taking measures to ensure stability in the market. We also acknowledge the important points raised by other constituents, including the broker community, Health Care For All and the provider representatives. Inherent in the collective submitted materials is the importance of Massachusetts maintaining a healthy, competitive, accessible market that maximizes the quality of care for patients and incentivizes dental practices to continue to adopt new technologies and care initiatives. As Delta Dental is committed to the work being done to ensure such advancements, we will focus our comments on these areas.

The ACA MLR regulations at 25 CFR 158.150 provide a framework for the inclusion of quality improvements in a loss ratio. Quality improvement activities should include programs administered by the insurer directly to patients, or through dental providers, that improve dental outcomes, enable the optimal oral health experience, lead to more equitable outcomes, and incentivize the modernization of care. Examples of such programs are preventing oral disease at lower costs for consumers, broadening access to care, focusing on the mouth-body connection to improve overall health, and increasing direct-to-consumer communications and education efforts. Similarly, implementation of technologies that improve diagnostic abilities such as virtual care, salivary diagnostics, AI and 3D radiology, imaging, and printing further innovate and improve standards of care in practice. Expenditures on efficiencies such as quality ratings, electronic billing, and the adoption of uniform coding assists in lowering overall cost to consumers and improving the provider's ability to focus on patient care rather than administration. In considering quality improvement activities, the Division should also look to the metrics and standards established by the Dental Quality Alliance for additional guidance, with special attention to those associated with the integration of care. Massachusetts is a laboratory for dental reform and permitting a broad range of quality improvement activities will allow the industry to modernize and innovate while providing real value to patients.

The passage of these DLR measures marks an inflection point for dental care in the Commonwealth. Voters' demand for improved value and a modern oral health system is recognized in this law. To foster true reform, the regulatory framework needs to incentivize innovation and value. Including quality improvement activities in the DLR pushes toward investment in modernization; a proscriptive regulation that caps quality activities would not only be arbitrary, but would disincentivize innovation. Similar to the medical space, quality activities benefit all participants - providers will be able to grow their practices, employers will have greater offerings for their employees, consumers will receive better quality care, and carriers can ensure efficiencies while continuing to re-invest in improving oral care.

Oral health is healthcare - and under MGL c. 176X, the Division should seek to promulgate regulations that maintain patients' access to affordable and quality dental insurance while ensuring that progress is

not hindered. Through the implementation of quality improvement activities, the Division can foster the modernization the oral health system to maintain and improve quality and access to care.

Thank you for your time and consideration. We look forward to continuing to work with the Division as it drafts these regulations.

Sincerely,

Erik Montlack
President
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March 30, 2023

Deputy Commissioner Kevin Beagan
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Re: Massachusetts Dental Society-Response to Division of Insurance Information Session #4 on Chapter 287 of the Acts of 2022 (An Act to Implement Medical Loss Ratios for Dental Benefit Plans)

Dear Mr. Beagan,

Thank you for the opportunity for the Massachusetts Dental Society (MDS) to submit comments to the Division of Insurance (DOI) to support the implementation of Chapter 28 of the Acts of 2022, "An Act to Implement Medical Loss Ratios for Dental Benefit Plans" (the "Dental MLR Act" or the "Act"). As the representative body of over 5000 dentists in the Commonwealth of Massachusetts, we would like to help ensure that the DOI regulations best serve individuals in the Commonwealth in receiving appropriate dental care.

In this final comment, we would like to first address some of our most foundational concerns related to the establishment of regulations to implement the Act, as well as reflect on the most recent session on March 15th. Secondly, we will respond to the questions posed by DOI and discussed at Session 4, held on March 1st, 2023, on the process to file and review rate materials under the Act.

I. Landscape Review and Act Transparency and Care Delivery Requirements

For the residents of Massachusetts as well as the dental provider community, it is of the utmost priority that the fundamental aim of this Act - to secure value for consumers in their transactions with Dental Insurers - is achieved.

It has been clear to the MDS that the patient value of dental insurance has been eroding. Coverage maximums have stayed essentially constant almost as long as dental insurance has existed. In 1977, annual maximums were "$1,000 or more," according to historical data.[1] In

[1] Private Health Insurance Plans in 1977: Coverage, Enrollment, and Financial Experience, (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191074/)

2023, the most common annual maximum is $1,500 and trending downward, while $1,000 in 1977 would be equivalent to nearly $5,000 today.[2]

Ultimately, it is the experience of Massachusetts dentists that every year the ability of dental insurance to protect patients is ever more diminished, making dental care less accessible and less affordable for the Massachusetts public. In this Act we see the mandate to reverse that trend and to secure quality dental benefits for the Massachusetts public, who endorsed this measure by voting overwhelmingly in favor of it in November of 2022.[3]

The implementation of the ACA demonstrates the ability of insurers to adapt to a new regulatory landscape. This history serves as an important counterweight to claims by the carrier community at several of the recent DOI listening sessions that a new regulatory rubric for the Act would pose serious administrative hurdles.

It is important to note that the ACA also provides important lessons in how well-intended state regulations permitting QIAs can be exploited with potentially negative consequences for consumers and patients. Federal regulation implementing the ACA now makes clear that quality metrics and incentives must be tied to measurable, well documented clinical standards. [4] Specifically, the Centers for Medicare and Medicaid Services (CMS) requires that "only those provider incentives and bonuses that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes. "[5] Recent CMS guidance also clarifies that " only expenses directly related to activities that improve health care quality may be included as quality improvement activity (QIA) expenses for MLR reporting and rebate calculation purposes."[6] This CMS guidance on QIAs speaks to concerns among our member dentists as well as dental patients about how a QIA caveat might be misused in the dental health context.

Additionally, Georgetown University Center on Health Insurance Reforms notes in a recent posting from a February 22, 2023:

"Although the extent of dental coverage was limited—only 21 percent had this type of coverage—the level of benefits was somewhat better. Forty-six percent of those with dental insurance had comprehensive coverage subject to deductibles and co-insurance, but with a maximum annual benefit of $1,000 or more."

[2] https://www.in2013dollars.com/us/inflation/1977?amount=1000#:~:text=%241%2C000%20in%201977%20is%20equivalent,cumulative%20price%20increase%20of%20396.44%25.

[3] https://www.nytimes.com/interactive/2022/11/08/us/elections/results-massachusetts-question-2-dental-insurance-regulation.html

[4] 45 CFR Section 158,150

[5] Ibid.

[6] Ibid; see also https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023

.

> "CMS has found that some insurers are sending payments to providers solely to raise their MLR, thereby reducing the amount of rebates they must pay to policyholders.
>
> … [T]he agency notes that MLR examinations have found incentive payments and provider bonuses triggered by the insurer's failure to meet the MLR standard itself, rather than providers' successful delivery of high-quality care or improvements in enrollees' health."[7]

Quality improvement should be a commitment of all stakeholders in the dental healthcare ecosystem. It creates concerns with the dental community to be discussing QIAs without first undergoing a robust process involving a wide array of dental health stakeholders to vet and determine evidence-based QIA.

A related concern is that there are insurance carriers who operate dental clinics in Massachusetts as well as nationwide. This dual role of carrier and provider poses certain additional concerns regarding what should count towards QIAs or other direct numerator costs. Specifically, these concerns include the potential for inappropriate self-dealing and different overall reimbursement levels to providers based on whether they are owned or operated by the carrier. Where dental insurers are also delivering care, there are significant concerns of how discretionary payments might flow to providers.

The MDS and its members believe including QIA in the numerator of the MLR calculation carries significant risk and places significant burden on the DOI to monitor carrier compliance in a way that compromises the foundational aims of the Act. Given the distinctions between the dental and medical insurance markets enumerated in our previous submissions, a record of QIA caveats being misapplied, and the fact that the underlying foundational aim of the Act is not compromised by not including QIAs, we believe it is in the interest of the DOI and the people of Massachusetts to maintain a simple Dental MLR calculation that excludes caveats that may only serve to undermine the spirit of the Act.

If the DOI does choose to include QIA, or a QIA-like, caveat, to the Dental MLR calculation, the MDS and its members emphasize our desire to see such a caveat be carefully delineated with clear clinically based criteria- with input from providers- and capped. To streamline comments for the DOI, MDS would be comfortable with the DOI considering the framework proposed in the Committee on Dental Insurance Quality (CDIQ) submissions for QIA. Additionally, we would like to take this opportunity to make clear that we recommend a maximum of 1% QIA cap (similar to the percentage in the medical space)[8]. Ultimately, measures must be taken to ensure that any and all expenditures that DOI regulation permits carriers to include as a QIA result in objectively measurable outcome improvements – for example, for distinct subscriber groups (e.g., patients with periodontitis)-, and are paid toward

[7] https://chirblog.org/questionable-quality-improvement-expenses-drive-proposed-changes-medical-loss-ratio-reporting/

[8] https://www.soa.org/globalassets/assets/files/e-business/pd/events/2019/health-meeting/pd-2019-06-health-session-014.pdf Slide 11

clinical services rendered by a licensed provider. Even with such prescriptions, we remain concerned that a QIA caveat in the MLR may only serve to complicate and undermine the Act as it may be used to deliberately or arbitrarily reward providers for non-quality-based activities.

Throughout the DOI information sessions and the comment process, dental carriers have repeatedly expressed concerns and even opposed basic reporting and compliance requirements- even though the Act itself is quite prescriptive in the types of information carriers will be required to provide. Medical insurers across the country have adapted to a system where MLRs are routinely measured and enforced, and dental carriers in California have reported dental MLRs since 2014. While those models are relevant reference/starting points, we recommend the DOI hew closely to the Act as written and recognize that the implementation of this Act presents the opportunity to improve and expand those models to ensure that consumer value in the dental insurance market is secured for years to come. To this end, we strongly encourage the DOI to err on the side of greater transparency and granularity whenever possible, such that the spirit of the Act can be ensured.

In the formulation of dental MLR calculations, we would like to emphasize an important point raised in our prior submission: there are instances where payments are made to subscribers that may not reach providers for treatments performed. For example, when patients see a dental provider who is “out of network,” many insurers refuse to follow the patient’s request that payment for covered services goes directly to the provider. Instead, the patient is required to pay the provider and then seek reimbursement from the dental carrier. This inevitably results in instances where reimbursements paid to patients do not actually reach the provider. Further, some patients may not seek or be able to obtain reimbursement from their dental insurer while still having received care and having paid dental premiums. These scenarios will skew the data if DOI does not require that only payments made directly to the provider are included in the MLR numerator. It is critical that only payments that reach providers is formulated into the MLR numerator.

Additionally, as we elaborate below, where carriers have unique product offerings and lines of business, we believe that the structures and templates for reporting must ensure that administrative costs are appropriately allocated across each entity on a pro-rata basis and are comparable across carriers. The manner of allocating expenses should be detailed, explained, and justified.

In sum, it is the sincere hope of the dental provider community who treat patients every day across the Commonwealth that the Act will help make our dental care delivery system a more sustainable, cost-effective, transparent, and fair system for the benefit, access, and health of all dental patients in the Commonwealth.

II. MDS Responses to Session 4 DOI Questions: Introduction

At the outset, the MDS would like to note that the Act is comprehensive in capturing all aspects of Massachusetts dental insurers’ business profiles to ensure that all necessary information is available for an accurate Dental MLR calculation. The Act specifically outlines the

reporting of data for lines of business not subject to the Act, precisely because costs are shared across products. If there is not any clarity on the relative size of parts of the business, then shared administrative costs may be allocated in a way that allows for inaccurate dental MLR reporting. Consistent with the terms of the Act, there simply cannot be areas of the business that are a black box; instead, full transparency of all lines of business will uphold the Act's intent to promote transparency and improved dental care on behalf of the Massachusetts public.

With regard to many of the questions raised by DOI concerning whether to require that carriers submit more detail versus generalities, the MDS believes that DOI should require greater detail. While we have no desire to introduce unnecessary administrative burdens, it is our belief that any information that is not included at the outset will be more difficult to add in later.

Finally, we would note that there currently is an established reporting structure that has existed in California for just under a decade. We believe that those structures should be considered an appropriate foundational starting.[9] That said, we believe the more robust the reporting requirements, the greater likelihood that the law achieves the desired outcomes.

Section 3.(a)

Generally, the MDS urges DOI to require that carrier reporting include all values and details that could potentially impact the DLR calculation. Where carrier costs are allocated across varying lines of business it would be necessary to capture out-of-state costs so that it can be assured that costs are apportioned appropriately on a pro-rata basis. Without out-of-state data, we believe the reported values would be more easily manipulated and undermine the goals and requirements of the Act.

For product delineations, where they exist (e.g., preferred vs closed network), they should be reported.

Section 3.(b)

While we again point to our comments above about a guiding preference for higher specificity, we would present, as a starting point, existing accounting principles established by California's Dental MLR reporting law.

For context, it is important to note that California passed a law in 2014 requiring dental plans to report MLRs but – in contrast to the recent Massachusetts law – did not set any

[9] State of California Department of Managed Health Care (DMHC) and Department of Insurance (CDI) Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions Pursuant to Health and Safety Code section 1367.004 and Insurance Code section 10112.26 California Division of Insurance Annual Filing Instructions;
https://www.dmhc.ca.gov/Portals/0/Docs/OFR/Dental%20MLR%20Instructions%20version%20date%2012_16_21_accessible.pdf?ver=2022-01-05-185020-873

minimum thresholds.[10] It is not clear whether the reporting requirement may have helped ensure more costs were directed to actual care. Even if so, it seems clear that behavior has not changed sufficiently under a reporting law that stopped short of requiring a minimum MLR. Specifically, even with this reporting law, the average weighted MLR percentage in California still fell well below the ACA standard-only 76%.[11]

The California Division of Insurance requires the following reporting by dental carriers:

"Acceptable Bases for Allocation of Expenses[12]

1) Allocation of each type of expense among dental service insurance markets should be based on a generally accepted accounting method that is expected to yield the most accurate results. If this is not feasible, the health plan or health insurer should provide an explanation as to why it believes a more accurate result will be gained from its allocation of expenses, including pertinent factors or ratios, such as studies of employee activities, salary ratios or similar analysis.
2) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management or administrative services contract, must be apportioned pro rata to the entities incurring the expense.
3) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate to a specific entity or sub-set of entities, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by that specific entity or subset of entities and must not be apportioned to other entities within a group."

Given the level of detail specified in the Massachusetts Act and the fact that, unlike California, it goes well beyond simple reporting to require carriers to comply with a new dental MLR of 83% (which the California reporting failed to achieve), we believe the requirements that DOI specifies for implementation should be significantly greater than the above-quoted California guidance. We provide it though as a point of reference, so that the DOI may build on another state's experience, noting that our Act is considerably more stringent.

Additionally, given likely differences in how companies may choose to allocate expenses, it is even more important that reporting requirements capture national expenditures in addition to those expended in Massachusetts. In instances where there are differences in how administrative costs are allocated across products, such differences should be clearly detailed, explained, and justified in submissions. This is especially important, and we would like to emphasize this point, where it is possible that some products (i.e., TPA products) may use less

[10] Medical Loss Ratios for California's Dental Insurance Plans: Assessing Consumer Value and Policy Solutions | Health Affairs
[11] Ibid.
[12] https://www.dmhc.ca.gov/Portals/0/Docs/OFR/Dental%20MLR%20Instructions%20version%20date%2012_16_21_accessible.pdf?ver=2022-01-05-185020-873; Section 2, page 21.

administrative capacity resulting in uncaptured higher administrative costs for products subject to the Act.

In general, and moving forward, the MDS would like to be involved in the development of the DOI's reporting templates. We believe that all carriers and plans should be held to these uniform standard-templates for report submissions. Further, we believe these templates must be detailed enough to compare line items across various carriers and plans.

Section 3.(c)

The MDS would encourage the DOI to err on the side of greater transparency to ensure dental MLR compliance with the Act. While benefits coordinated in Massachusetts should be measured, it is important to include all benefit structures insurance carriers administer, including so-called self-funded plans, so that how administrative costs are allocated across all product lines may be assessed.

As far as measuring loss ratios for self-funded accounts we believe the MLR should be calculated via the same formula for fully-insured plans (i.e., plans where a contract of insurance has been issued and the insurer carries the risk). However, there is an implicit measure of MLR in self-funded accounts with which the standard MLR calculation should cohere (the difference between payments for dental services, compared with those payments and the fees for administration). Where there appears to be inconsistency in the administrative costs of fully-insured plans compared to self-funded plans, insurers should be required by DOI to detail, explain and justify these disharmonies such that administrative costs are not arbitrarily transferred onto products not subject to the Act.

It is therefore critical that the DOI collect information on the cost of administering self-funded lines of business so that expenses can be allocated appropriately across lines of business.

Section 4.

We feel it is very important that reporting requirements capture a broad and detailed view of dental carrier’s entire business. The Act comprehensively addresses this issue by requiring broad reporting. Self-funded plans administered by carriers are subject to the MLR minimums established by the Act. We believe this is clearly delineated in section 3(c) with limited carve out in Section 4 which excludes self-funded plans that are self-managed or managed by non-carriers.

Conclusion

In closing, it is of paramount importance all regulations adopted to implement the Act protect patients, ensure benefits are directed toward care, and ensure insurers are adhering to the Act’s patient protection and cost transparency mission. We appreciate being a part of this process and hope to contribute where necessary to help achieve a healthy and sustainable market for providers and carriers alike, in service of providing the best care to individuals receiving dental services in the Commonwealth.

Thank you for the opportunity to submit these comments on the implementation of regulations for the Dental MLR Act. The MDS appreciates the consideration by DOI of these comments and concerns. Please contact me at kmonteiro@massdental.org or 800.342.8747 if you have any questions about these comments.

Respectfully submitted on behalf of the Massachusetts Dental Society,

_____

By: Kevin Monteiro
Title: Executive Director

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Kevin Beagan, Deputy Commissioner, Health Care Access Bureau
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

RE: Chapter 287 of the Acts of 2022

Dear Deputy Commissioner Beagan and General Counsel Butler,

Health Care For All believes that voters in Massachusetts supported Ballot Question 2 (Chapter 287 of the Acts of 2022, An Act to Implement Medical Loss Ratios for Dental Benefit Plans) because they believed it would result in them getting better value and better benefits from their dental benefit plans. This goal should therefore be the guiding principle for implementation of the law, and the regulatory guidance issued by the Division of Insurance (DOI).

The aim of the regulations should be to ensure that consumers receive more expansive dental benefits and coverage with less out-of-pocket costs to improve access to dental care without increasing premiums or out-of-pocket cost. Dental care is already the top category of care that Massachusetts residents forgo due to cost. According to recent CHIA data, 19.2% of Massachusetts adults could not get the dental care that they needed due to cost. It is critical that DOI carefully considers how to protect consumers and prevent worsening existing financial barriers to dental care. Massachusetts needs a more equitable and cost-effective oral health care delivery system that ensures everyone in the state has the opportunity for quality, affordable oral health care in the setting that works best for them.

It is particularly important to avoid dental loss ratio implementation resulting in dental benefit plan premiums increases without any expanded, enhanced, or improved benefits for consumers. To the extent that DOI must consider dental benefit premium increases through its review process under Chapter 287, these increases should only be considered allowable when they are linked directly to explicit increases in consumer coverage, access, and/or quality of dental care. Some minimal premium increases could be considered allowable, if they are justified by being directly linked to innovative benefit plan design or meaningful quality improvement initiatives which materially improve the health and well-being of beneficiaries.

However, premium increases that are not shown to be linked directly to more generous covered services, enhanced access, and/or higher-quality dental care would be the worst possible outcome and should not be considered for approval under the DOI review process.
The DOI regulatory framework for implementing Chapter 287 should reflect these principles and values. It should ensure that implementation process reflects the will of Massachusetts voters and results in dental benefit plans with better value and better benefits for consumers.

Sincerely,

Dr. Samantha Jordan
Oral Health Director
Health Care For All

April 3, 2023

Gary D. Anderson, Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston MA 02118-6200

Dear Commissioner Anderson:

On behalf of the Massachusetts Association of Health Plans, which represents 14 health plans and two behavioral health organizations that provide coverage to nearly 3 million Massachusetts residents, we appreciate the opportunity to submit written comments to the Division of Insurance (Division) relative to the implementation of M.G.L. c. 176X, statutory changes to dental insurance in Massachusetts enacted via ballot question. At the outset, MAHP seeks to establish certain key principles fundamental to facilitating the continued evolution and modernization of the dental benefit market in Massachusetts for the benefit of consumers. Dental benefits are an insurance product designed to provide preventative services fundamental to the health of individuals – oral care is healthcare. Without access to affordable insured dental products, including those offered through the Connector, many Massachusetts residents would go without dental benefits, which will ultimately put more costs on the health care system. Dental coverage is based on predictable access to services and reimbursement rates are negotiated with the many individual and smaller group dental practices throughout the state. It was alarming to hear the representatives of the provider community indicate that the potential withdrawal of carriers from the Massachusetts dental market was not concerning and that loss of affordable coverage for consumers was an acceptable risk in the implementation of the regulations to enforce M.G.L. c. 176X. At the heart of any statutory effort seeking to further regulate an already regulated industry should be the benefit to the consumer – in this case, any dental patient – receiving or seeking dental care. Accordingly, MAHP supports the implementation of regulation that does not destabilize a healthy, competitive market and that encourages innovation in plan design and benefits. Consumers currently have options when it comes to dental coverage – whether on the individual side or through their employers. Small businesses similarly have the ability to offer generous benefits to their employees – and larger employers are able to utilize years of data to ensure they are getting the best price for what they offer to their employees and their families. Carriers need flexibility to develop innovative programs and benefit plans to ensure they remain competitive. This means they also need to be flexible in rating to accommodate groups that choose to remain in the admitted market where consumers are best protected.

We respectfully request that close consideration be given to the complexity of the provisions of the new law as your office works to draft regulations incorporating novel statutory language into the Division's existing oversight framework. Our specific recommendations are as follows:

Definitions
The definitions included in the regulations must be clear and unambiguous to ensure that new processes are conducted in a consistent fashion that does not unnecessarily create additional regulatory barriers that adversely impact access to dental benefits or drive up the cost of coverage for families and small businesses. The statutory language is clear that the term "carrier" applies to insurance carriers licensed in Massachusetts. This includes an insurance company authorized to provide accident and health insurance under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, and a nonprofit medical service corporation organized under chapter 176B, and a dental service corporation organized under chapter 176E. Additionally, "dental benefit plans" only applies to a fully-insured plan issued, renewed or delivered within the Commonwealth. The definition of "dental benefit plans" does not apply to self-funded employer-sponsored dental benefit plans or to third-party administrators that may perform certain administrative tasks for self-funded plans. The statutory language in chapter 176X, § 4 makes clear that self-funded plans are not within the scope of the law- "This chapter shall not apply to dental benefit plans issued, delivered or renewed to a self-insured group or where the carrier is acting as a third-party administrator." Additionally, the term "dental benefit plans" should apply to non-insurance dental discount plans when providers are acting as an insurer.

The statutory language of the new law is intended to apply to "dental benefit plans" that are "stand-alone." We ask that the Division clarify in the regulations that the term "stand-alone dental plans" does not include plans with dental benefits incidental to the plans' benefits and does not include Qualified Health Plans (QHPs) offered on the Exchange that include pediatric dental Essential Health Benefits (EHB) coverage that is offered co-bundled, as a dual certificate, as a rider, or embedded. Pursuant to 45 CFR § 156.110, QHPs must provide pediatric dental benefits as a supplement to meet the EHB requirement. Carriers licensed under M.G.L. Chapters 175, 176B, and 176G can offer QHPs with embedded pediatric dental benefits, but we do not believe Chapter 176X is intended to regulate such products, and it is important for the Division to make that distinction clear to avoid duplicative or contradictory regulatory requirements. The definition of "stand-alone dental plan" in section 1 of Chapter 176Q would appropriately make this distinction. MAHP supports minor revisions to the definition included in existing Health Connector statute M.G.L. Chapter 176Q, Section 1, which defines "Stand-alone dental plan" as "a nonprofit dental service plan offered by a licensed dental service corporation, as those terms are defined in section 1 of chapter 176E, offered independently of a health benefit plan offered through the connector or offered independently of a health benefit plan offered by: (i) an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; (ii) a nonprofit hospital service corporation organized under chapter 176A; or (iii) a nonprofit medical service corporation organized under chapter 176B."

Chapter 176X does not apply to dental benefit plans issued, delivered, or renewed outside of Massachusetts, nor does it apply to carriers licensed out-of-state that provide coverage to Massachusetts residents. The Division's authority extends to carriers licensed in Massachusetts. This means that the law covers Massachusetts residents that are individual policyholders on a dental benefit plan initially issued and which continues to renew in Massachusetts and small and large group employees covered by a dental benefit plan issued by a Massachusetts-licensed carrier to a group policyholder situsted in Massachusetts, regardless of the address or location of the employees covered under the plan or coverage.

Finally, the Division should provide definitions for other terms utilized throughout the new statute consistent with existing state insurance regulations where applicable. Specifically, the Division should utilize definitions from the recently-updated small group regulations, 211 CMR 66, to clarify

terms used in 176X, section 2(c) for purposes of rate filing and for the financial statement required to be submitted under 176X, Section 3(b). Definitions that can be leveraged from 66.08 include: Charitable Contributions Expenses, Claims Operations Expenses, Distribution Expenses, Financial Administration Expenses, Marketing and Sales Expenses, Medical Administration Expenses, and Network Operations Expenses. However, these sections concern reporting and do not reflect factors to be used in the calculation of Dental Loss Ratio and these definitions should not be used for this purpose.

Dental Loss Ratio Methodology and Refunds

The regulations developed by the Division must establish a definition of Dental Loss Ratio (DLR) that clarifies the formula for carriers offering dental benefit plans to calculate loss ratio. While Chapter 176X established a medical loss ratio (MLR) for dental benefit plans, the term "dental loss ratio" is not defined in the statute. Section 3 of the statute directs the Commissioner of Insurance to create regulations "consistent with this act," and we recommend the Division develop such a definition so that market participants have certainty about its calculation and application. As Massachusetts is the first state in the country to implement a DLR, we suggest the Division adhere to commonly accepted industry principles developed as part of the MLR regulatory process when creating the definition and application of a dental loss ratio. In 211 CMR 147.00, the Division defers to both "federal guidance" (established pursuant to the Affordable Care Act) as well as the "methodology established by NAIC" (National Association of Insurance Commissioners) in defining MLR. Therefore, to the extent possible, the Division should rely on existing federal rules and guidance and the methodology developed by the NAIC relative to the MLR when establishing the DLR formula.

Specifically, expenses for state and federal taxes, assessments, and fees should be excluded from earned premium, consistent with ACA regulations. Similarly, the calculation of a DLR should permit carriers to include, as dental expenses, quality improvement activities, and costs associated with detection, prevention, and recovery of fraud, waste, and abuse (FWA) activity. Lastly, any other payments made to providers, in addition to fee-for-service claims, including but not limited to charges for personal protection equipment (PPE) should also be included in the loss ratio calculation. Much like their use in the medical space, dental quality initiatives will incentivize equitable member access to dentistry, preventive care, disease management and the utilization of technologies that will enhance the dental experience for patients. Adoption of quality improvement activities not only assures patient benefit, but also permits flexibility in a modernizing industry as it moves toward a value-based system. Quality Improvement Activities should include programs that are: administered by the insurer, directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or to provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; increase clinical wellness and promotion of health activities; produce clinical outcomes that can be objectively measured and verified, and are supported by evidence-based medicine, best clinical practices, or criteria issued by professional dental associations, Massachusetts governmental agencies, or other nationally recognized health care quality organizations.

According to the 2020 *Oral Health in America: A Report of the Surgeon General*, "Oral health and disease affect all aspects of our society, from our financial well-being to our health care systems and even our ability to communicate with others." Dental insurance carriers play a critical role in improving oral health and overall health outcomes. Carriers conduct a number of quality improvement activities designed to improve health outcomes. Some examples include:

- Outreach to members with care reminders to increase preventive visits. Consumers with dental insurance were more than 1.5 times more likely to get care than those without in 2021 (NADP Survey of Consumers).
- Programs designed to improve the health of those with systemic conditions such as diabetes, hypertension and heart disease. One carrier's members experienced a 22% decline in hospital admissions, a 10% increase in preventive dental care, 5% lower medical costs, a 45% improvement in diabetes management, and 27% lower risk scores for chronic conditions for individuals with qualifying conditions who receive targeted outreach.
- Programs to reduce opioid use including provider education, implementation of coverage alternatives, and proactive member outreach. Dentists prescribe 10% of all opioids in the United States and are the number one prescriber of opioids for patients aged 10 to 19. One carrier saw a 19% reduction in opioid prescriptions as a result of targeted opioid reduction programs.
- Programs to improve health equity including professional partnerships and community education.

Moreover, DLR and rebates should be calculated in the aggregate across all market segments for a carrier. Dental carriers operating in Massachusetts may have relatively few policies in a market segment and therefore have less predictable claims expenses. To require dental carriers to report their MLR by market segment could have a significant adverse impact on the viability of the dental market in Massachusetts. Dental loss ratios calculated using aggregate data will ensure that rebates are not based on the experience of an individual enrollee or group, but on a dental carrier's overall compliance with applicable DLR standards. We further recommend that the Division permit a credibility adjustment to the calculation based on membership volume to avoid volatility of results. Carriers with extremely low enrollment in Massachusetts dental benefit plans should be deemed in compliance with the state's DLR requirements. Credibility adjustments to MLR calculations are permitted by the ACA to be determined by enrollment levels on a state-by-state basis in each market segment. Medical carriers with the fewest enrollees, less than 1,000 member-years or 12,000 member-months, are called "noncredible" and are therefore presumed to be in compliance with ACA's MLR requirements. Similarly, dental carriers should be exempted from the DLR reporting and rebate obligations when their Massachusetts membership numbers are insufficient to justify the administrative workload. The calculation of DLR should utilize a 3-year look back and DLR rebates should be based on a three-year average of a carrier's experience. Finally, the Division should establish an appropriate de minimis standard below which carriers are not required to refund amounts to individuals or groups to reduce the administrative burden on carriers and employers associated with the notice and issuance of refunds. Chapter 176X, section 2(d) states that the Commissioner may authorize a waiver or adjustment of the rebate requirement if the Commissioner determines that issuing such rebates would result in financial impairment for the carrier. The ACA permits carriers to avoid issuing rebates in circumstances where the rebate amounts are so minimal that they do not justify the additional expenses of processing. Dental benefit plans are a low-premium product, especially in comparison to medical coverage. In most instances, the DLR calculation will result in extremely low rebate amounts, likely lower than the administrative cost to issue the rebate. Additionally, we propose that rebates issued should be subtracted from premium revenue in the denominator in the subsequent year to appropriately reflect the portion of premiums that are not retained by a carrier or utilized to cover the costs of member care. We recommend that the Division establish the above protections to maximize the value to consumers and avoid unintended consequences such as increased premiums, reduced access to dental benefits, or limited employer and consumer options for affordable dental coverage in the Commonwealth.

However, because of the differences between medical and dental insurance, some modifications to the MLR methodology will be necessary. We respectfully recommend that broker commissions be subtracted from premium revenue in the denominator of the DLR formula since this expense is generally a pass-through expense paid on behalf of the insured individual or group. As suggested in prior comments received by the Division, broker commissions for standalone dental products average around 10% of total revenue. These costs are not retained by the carrier; after the 2.28% premium tax in MA, in an 83% loss ratio environment, carriers are left with no more than 5% of revenue to provide member services, contract with providers, adjudicate claims, and cover a wide range of administrative services. This would inevitably compromise a carrier's ability to best serve its members, which is not the intent of 176X. Alternatively, a reduction in broker compensation may introduce barriers to access to coverage and care, which is also not the intent of 176X.

Rate Filings

Rate filings should be submitted separately by individuals and groups including, if relevant, small groups (less than 50 employees), and large groups, if appropriate for review. Dental coverage is typically offered to individuals (through the Connector and directly) and to groups. Groups smaller than 50 rely upon actuarially sound group base rates and group rating factors. Groups larger than 50 rely upon experience rating when available, where an employer is able to negotiate favorable rates for adopting certain practices that encourage better health within their population. The market is voluntary, meaning adverse selection is prevalent on the individual side, and the individual and group markets are rated and administered separately. Dental carriers in Massachusetts have historically submitted products for the Division's review in this manner and to require submissions on an alternative basis would have an impact on the rates charged to members and would cause disruption in the rates charged.

The rate filing requirements in Chapter 176X do not apply to the individual market. Section 2(f) requires carriers to communicate to impacted members, specifically "employers and individuals covered under a group product", when a proposed rate change has been presumptively disapproved by the Division. Section 2(c) of Chapter 176X requires carriers to file "*group product* base rates" and "changes to *group* rating factors" annually. However, individual dental business does not use group product base rates or group rating factors. MAHP recommends that the Division continue to utilize the process currently in place for the submission and review of rate filings for the individual market (i.e. rate filings are required only for new products or for existing products with rate changes) to ensure statutory compliance and appropriate transparency, while limiting the burden on dental carriers and the Division.

For purposes of clarity and consistency, "Group Base Premium Rates" should be defined as the base premium rate to be charged to Eligible Small Businesses for all Eligible Employees and Eligible Dependents prior to the application of Rating Adjustment Factors. "Group Rating Factors" should be defined as any actuarially sound factor unless prohibited or discriminatory. The new statutory language is silent on allowable rating factors, therefore dental carriers should be permitted to use industry-accepted rating factors and to continue utilizing experience rating to vary premiums based on an enrollee's or group's medical history, age, geographic differences, and claims experience. Because dental insurance is not mandated coverage, adverse selection is often present in membership. The risk to a dental carrier is higher because coverage is most commonly purchased by individuals with significant treatment needs. If carriers are not permitted the flexibility to continue developing rates using factors that reflect the experience of a market segment, premium rates may not be sufficient, creating the potential to disrupt the market. MAHP asks that the Division permit

carriers the flexibility to apply a number of allowable rating factors, including but not limited to: Experience factor, Plan factor/Benefit factors, Network factor, Group size factor (including small group factor for groups of 1), Age/gender factor, Standard industrial classification (SIC) factor, Participation/contribution factor, Area/geographic factor, Prior coverage factor. We appreciate that these factors will need to be actuarially supported to satisfy the Division's review.

Rate filings for dental benefit plans should be submitted annually if necessary (i.e., where there are new base rates or changes to rating factors contemplated). We recommend that the regulations make clear that carriers are not required to file rates with the Division if there are no changes to base rates or rating factors. In addition to the annual filing due on July 1, MAHP proposes that the Division consider allowing optional quarterly filings to enable carriers to address potential base experience variability arising from the market disruption that will likely ensue from Chapter 176X. Given the rising inflation and wage increases in recent years. plans should be permitted to file monthly or quarterly trend adjustments to apply to rates to align with the expected continuous increase in costs throughout the year. It is well understood that it is inappropriate to charge the same rate for a policy effective 1/1 through 12/31 and a policy effective 12/1 through 11/30 of the following year, as there would be 11 months of trend buildup that would not be reflected in these rates.

We respectfully request that the Division notify dental carriers of approval within 45 days from the rate filing submission date. As renewal quoting may occur well in advance, disapproval notices to carriers 45 days prior to the proposed effective date may not be timely and may impact the carrier's operations, client satisfaction, and market stability.

Finally, in the interest of preserving existing coverage for Massachusetts residents, the Division should not require carriers to file rates for products that are not being offered for purchase (closed blocks of business) if they have minimal members enrolled. Such enforcement relief will ensure that carriers can continue to serve longstanding members and that existing coverage will be preserved for individual policyholders.

Presumptive Disapproval

For purposes of Chapter 176X, Section 2(d), MAHP requests that the CPI used to evaluate the administrative expense loading component of the filed base rate be based on the most recent month with enough lead time for rate development – i.e., March or April ahead of a July 1st filing date. The "most recent calendar year's percentage increase in the dental services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted)" should be calculated by dividing the index value for the March period preceding the date of the filing by the same index value from the March period one year earlier. For purposes of Chapter 176X, Section 2(d), "Dental services consumer price index" should be equivalent to the Dental Services Consumer Price Index for Urban Consumers (CPI-U), U.S. city average and selected areas, for the Boston-Cambridge-Newton area. This measure tracks consumer out-of-pocket spending on services performed by dentists, oral or maxillofacial surgeons, orthodontists, periodontists, or other dental specialists in group or individual practice. Although MAHP acknowledges that the increase or decrease in the price of dental services is not the same as the changes in the cost of covering claims, we are aware there is a need to use a predictable benchmark. We urge the Division to consider a CPI standard that is based on the greater of the most recent year or the 3 or 5-year avg, for smoothing. Finally, we request the Division calculate and announce this statistic annually so that carriers are aware of it when submitting rate filings.

The Division should define "contribution to surplus" for purposes of presumptive disapproval. MAHP recommends the Division consider a higher threshold than 1.9%, recognizing that there is little room for contribution to surplus with the minimum loss ratio at 83%. Given the relative magnitude of dental premiums compared to those for comprehensive medical coverage, a 1.9% cap does not offer a meaningful way for dental carriers to build capital. Additionally, the Division should utilize the definition of "risk-based capital" included in 211 CMR 25. Risk-based capital (RBC) should be reported to the Division and reviewed on a combined entity basis. RBC is intended as a measure of solvency and the regulations should reflect that purpose. Finally, the Division should define terms including Direct premiums earned, Realized capital gains and losses, Net income, Accumulated surplus, Accumulated reserves.

Reporting Requirements

We recommend that the Division utilize the discretion granted to the Commissioner in 176X, section 3(d) in the establishment of "criteria for the standardized reporting and uniform allocation methodologies" of carrier financial information. The primary goal of this section is to provide transparency into the costs of the administration of dental insurance; the Division should not promulgate regulations that add to those costs. As you are aware, the language included in section 3 was copied from statutory language imposed on medical carriers that has since been repealed and replaced. Moreover, dental carriers were explicitly removed from these financial reporting requirements even before the repeal, in recognition of the duplicative and burdensome impact of the particular obligations. Much of the information referenced in section 3 is redundant, as the Division already collects this data in the annual report each carrier files. Additionally, carriers will be submitting information related to administrative expenditures to the Division in their annual rate filings. Therefore, we ask that the Division be thoughtful as they finalize reporting requirements in regulation to avoid imposing extensive provisions that will require significant administrative and operational work by carriers to implement new processes and procedures when this information is already available elsewhere.

If the Division chooses to have carriers report all the information in section 3, the following comments should be considered: The annual comprehensive financial statements in Section 3(a) should be compiled at the same segmentation detail as that for the suggested refund calculations, at the legal entity/enterprise level rather than by group size and line of business. Requiring forced segmentation would undermine transparency goals. Additional granularity in reporting may shrink certain buckets and lead to potential misinterpretation of results to the benefit or detriment of members, providers, carriers and other stakeholders due to loss in statistical validity. For the same reasons, reporting segmentation by network offering is not suggested. For the administrative components identified in (xi) through (xxi) in section 3(b), we believe that the categories, as outlined, are sufficiently prescriptive to create standardized administrative expense results across plans. The allocation of such expenses across companies, lines of business, and group size categories should be completed based on each individual carrier's accounting methodology, which recognizes a carrier's unique structure, including and not limited to lines of business, geographic footprint, number of legal entities, product portfolio, etc. Items (viii) through (x) in section 3(b) (accumulated surplus, accumulated reserves, and NAIC RBC ratio) should be reported at the enterprise level, consistent with the state regulation on medical filings. The Division should define terms used in 176X, section 3, to ensure consistency among carrier reporting, including: direct premiums (b)(i); direct claims incurred (b)(i); aggregate number of members (c)(ii); and aggregate value of direct premiums earned (c)(iv).

Section 3(c) is intended to impose financial reporting requirements on TPAs. The Division should consider removing the reporting requirement related to self-insured plans, especially as it relates to confidential and proprietary information, as self-funded plans are exempted from the requirements of c.176X, § 4. We respectfully request that the Division confirm with federal regulatory agencies, including the Department of Labor, the applicability of the reporting requirements on self-insured plans, which may be governed by ERISA and therefore would be subject to federal preemption to these new state reporting requirements.

Finally, we ask that the regulations issued by the Division make clear that any information submitted by dental carriers to the Division that is proprietary must remain confidential and shall be exempt from public record. We support the establishment of a process for carriers to identify information that is proprietary or confidential and communicate the reason or contractual requirement behind the proprietary or confidential information to the Division prior to submitting sensitive information in documentation to the Division. If the Division determines that the interest of policyholders or the public will be served by the publication, sufficient time should be provided for a carrier to notify any third party that may be impacted.

Timing of Implementation

MAHP plans have concerns about the timeline for implementation of the new statutory requirements. We respectfully request that the Division provide clarity to dental carriers about the Division's expectations over the next year as Chapter 176X is being implemented. As you are aware, the new law establishes a deadline of October 1, 2023 for the promulgation of regulations by the Division. While the statutory language also requires dental carriers to submit rate filings to the Division annually on July 1 for products to be offered beginning January 1 of the following year, it will be impossible for plans to develop comprehensive filings absent final regulations. Until regulations are promulgated, the lack of clarity in many of the novel provisions in the statute would make compliance difficult. Absent clear and comprehensive guidance, dental carriers could be subject to disapproval for failure to comply. Such a disapproval would have a material impact on dental carriers and could threaten the availability of coverage for existing members in the state. State law in Massachusetts requires that state agencies undergo an extensive process to draft, propose and file regulations that are procedurally correct and easy to understand. Prior to adopting a regulation, the Division is required to hold a public hearing and allow for a public comment period. Sufficient notice must be provided to interested stakeholders at least 21 days in advance of the public hearing. Even if regulations are drafted, heard, and finalized prior to July 1, 2023, dental carriers will not have adequate time to compile and review the necessary information required for submission to the Division. Finally, Section 4 of the adopted ballot question language states that Chapter 176X shall apply to all dental plans issued, made effective, delivered or renewed on or after January 1, 2024, making the requirements on dental carriers effective in 2024. Therefore, it is our expectation that dental carriers will be required to submit their first filings for premium rates on July 1, 2024 for plans effective or renewed on or after January 1, 2025. This will allow sufficient time for the Division to develop comprehensive regulations and comply with state notice and hearing requirements, as well as craft and issue subsequent filing guidance notices, detailed instructions, and standardized templates for the collection of plan data.

Maintaining access to affordable, high-quality dental insurance for Massachusetts residents is essential. We appreciate the Division's commitment to developing regulations that maximize the value to consumers and do not produce unintended consequences such as increased premiums, reduced access to dental benefits, or limited employer and consumer options for affordable dental

coverage in the Commonwealth. We look forward to working closely with you as you draft regulations and thank you in advance for your consideration.

Sincerely,

Elizabeth Murphy
Vice President of Regulatory and Legislative Affairs

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
Boston, MA 02118

Re: Regulations Comments Regarding Chapter 287of the Acts of 2022 - "An Act to Implement Medical Loss Ratios for Dental Benefits Plans."

Dear Deputy Commissioner Beagan and General Counsel Butler,

The Massachusetts Academy of Pediatric Dentistry (MAPD) has reviewed the many submissions that stakeholders have made during Comment Sessions 1-4 of the subject heading regulations.

The MAPD has taken the position that it fully agrees with the written and oral comments provided by the Committee on Dental Insurance Quality (CDIQ), its chairman Dr. Mouhab Rizkallah, and its attorney Matthew Perry.

OF PARTICULAR IMPORTANCE TO AID ARE THE FOLLOWING 2 POINTS:

1. **THE MLR NUMERATOR DEFINITION**: (Incurred Claims + Quality Improvement Activities)

- **INCURRED CLAIMS:** As described by CDIQ, Incurred claims must only include payments ultimately received by the provider for dental services. This means that payments *meant* for the provider and not *received* by the provider (such as payments made directly to patients that do not reach the provider) are not counted in the numerator. Fraudulent losses of this type are part of an insurance company's fraud administration expense.

- **QUALITY IMPROVEMENT ACTIVITIES (QIA):** We agree with CDIQ that QIA's should not be allowed in the MLR numerator. However, if the DOI determines it will allow QIA's, we agree with the CDIQ's proposed QIA limitations (below).
    - **QIAs shall:**
        - Be available only ***through*** providers.
        - Be equitable to all patients.
        - Require clinical expertise.
        - Increase clinical wellness and promotion of health activities.

- Produce clinical outcomes that can be objectively measured and can produce verifiable results.
- Be 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).
- Be supported by evidence-based medicine, best clinical practices, or criteria issued by professional medical associations.

- **QIAs shall not:**
  - Have any overlap with administrative expense items specified under Section 2(b)(i)-(x).
  - Have any marketing component that displays the name of the insurer.
  - Be paid by the insurer to **any** affiliate of the insurer in any way, either directly or indirectly.
  - Be greater than 1% of premium revenue.

2. **ADMINISTRATIVE EXPENSE CATEGORIES**:
   - **SECTION 2b** should be closely followed for categorization of administrative expenses (not the Federal ACA categorization).

   - **SECTION 2b** specifically deems the following as administrative expenses:
     i. Financial Administration Expenses
     ii. Marketing & Sales Expenses
     iii. Distribution Expenses (which includes broker commissions)
     iv. Claims Operations Expenses
     v. Medical Administration Expenses (such as disease management, care management, utilization review & medical management activities).
     vi. Network operations expenses
     vii. charitable expenses
     viii. board, bureau, or association fees
     ix. state and federal tax expenses (including assessments)
     x. payroll expenses

Thank you for reviewing our submission.

DDS, MS

Dr. Derek Zurn DDS, MS
President
Massachusetts Academy of Pediatric Dentistry

National Association of Benefits and Insurance Professionals
Massachusetts Chapter
NABIP
Shaping the *future* of healthcare

March 28, 2023

Mr. Kevin Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street
Boston MA 02118

Re: Comments on Implementation of Chapter 287 of the Acts of 2022 (An Act to Implement Medical Loss Ratios for Dental Benefit Plans)

Dear Deputy Commissioner Beagan:

The National Association of Benefits and Insurance Professionals – Massachusetts (NABIP-MA) is pleased to weigh in on the implementation of Chapter 287. We thank the Division of Insurance for providing the opportunity for NABIP – MA and other interested parties to provide oral and written comments on the implementation of this law.

Who We Are

NABIP – MA (formerly the Massachusetts Association of Health Underwriters, or Mass AHU) is a member-based organization that represents benefits and insurance professionals, their Massachusetts-based clients who sponsor employer benefits, and their clients' employees who receive those workplace benefits. Our organization's goals are to inform and to educate policy makers and the public about opportunities to increase access to medical and other health-related coverage, keep premiums in check, and foster a vibrant market that encourages innovation and maintains competition among large and small carriers.

Introduction

We agree with the voters' underlining sentiment that dental insurance administration costs should be well managed. The primary purpose of dental insurance should be the provision of strong patient care, and dental carriers should not make unreasonable profits at the expense of the consumer. We as benefits brokers work on this every day on behalf of our clients, measuring plan loss ratios, negotiating down premiums, and marketing dental carriers against each other. We absolutely want to see dental insurance costs well managed now and going forward.

That said, it is also in the Massachusetts' voters' interest to have access to a robust, stable dental insurance market without premium cost spikes. We do not want to see dental carriers exiting the market because we make the implementation of the law too onerous. If some carriers leave, the first markets to be impacted will be individuals and small businesses. We also do not want to see insurance premiums and patient out of pocket costs rising unreasonably as this law is implemented. We have too many other economic challenges right now to add that additional cost pressure to our residents. We are especially worried about the smaller dental carriers who serve the individual and small business markets.

Prior to the ballot vote, we had worked with the coalition of carriers and other interested parties that opposed Question 2 on the 2022 ballot. We did so because we believe that the following:

- The proposed loss ratio target was arbitrary,
- It doesn't reflect the reality of the cost structure in the dental insurance market, and
- The ballot measure could destabilize the market, increase premiums, and result in small carriers' leaving the Massachusetts market.

With the overwhelming passage of Question 2, we have shifted our focus to implementation of the new law, definition of terms, and factors that we believe do and do not belong in the calculation of the dental-loss ratio so that we can maintain a vibrant market for Massachusetts employers and their employees and dependents.

Our Concerns

The target ratio is arbitrary and doesn't reflect the financial realities of the dental market. An 83% minimum loss ratio in the medical-insurance market is achievable when self-only and family premiums often exceed $9,000 and $22,000 annually. With a high denominator, administrative expenses like office real-estate, information infrastructure, customer service, account administration, claims payment, network maintenance, marketing and sales expenses, compliance, and quality initiatives – can fit within an 83% target.

Dental premiums (the denominator) are typically about 1/15 of medical premiums, yet expenses are lower by a factor far less than 1/15. We understand the 83% figure is fixed by law. We have some suggestions below on making the law more workable with a careful definition of the expenses included in the calculation.

A dental minimum loss ratio favors insurers with multiple lines of business, at the expense of the consumer. Carriers who offer multiple lines of insurance, particularly medical insurance, can meet a dental loss ratio by allocating administrative costs. A medical/dental carrier using shared customer-service, claims, IT, compliance and sales and marketing can both leverage economies of scale and assign these costs to the two insurance lines as it chooses. This carrier can meet the 83% minimum loss ratio with little or no change to its existing premiums, administrative costs, and reimbursement to providers by merely allocating expenses differently within the larger organization.

In contrast, a smaller insurer with fewer lines of insurance that command lower premiums doesn't have this flexibility in expense allocation. It may not be able to meet the 83% target without increasing reimbursements to providers substantially. The net effect is that premiums rise, and the carrier is less competitive in the market. This result harms competition.

Example 1: A dental-only insurer has premiums totaling $10 million and expenses of $2.5 million (with $7.5 million spent on claims reimbursement. Even if the insurer cut administrative expenses by 10% (to $2.25 million) it would have to raise total premiums to $13.25 million to achieve an 83% minimum loss ratio. The additional $3.5 million of premiums would flow directly to dentists in the form of additional reimbursement. These higher allowable charges would move reimbursements – and thus premiums – higher throughout the market.

Moreover, as higher dentist reimbursements are implemented, patients will pay more out of pocket as they pay their coinsurance (percentage) share of services.

***Example 2:** Type 2 Expenses such as Fillings are usually paid at 80% (after the deductible), with the patient responsible for the 20% balance. At $100 for a filling, the plan pays $80 and the patient pays $20. At an increase to $120 for a filling, the plan would pay $96 and the patient would now be responsible for the $24 balance, or 20% higher out of pocket cost at the time of service.*

This is not the result voters intended.

The ballot question can destabilize the market. The introduction of a minimum loss ratio, without proper implementation, makes it difficult for smaller carriers to continue to operate in the market. Many of the Commonwealth's dental carriers are either foreign or have substantial business out-of-state. If they cannot comply with the 83% target, they are more likely to abandon the market. Doing so would deprive the Commonwealth's dental market of the price competition and innovation (including coverage for new benefits and quality initiatives) that are less common when a market has fewer, larger, entrenched competitors.

In a February meeting among members of the NABIP – MA board of directors and a half-dozen dental carriers, we learned that some of those attendees and other carriers not represented were reassessing their commitment to remaining in the market, especially as it relates to individual and small group coverage. A loss of a handful of these carriers would alter the Massachusetts market.

We have seen the effects of market consolidation with respect to medical carriers, hospitals, and medical groups. Less competition leads to higher prices without a corresponding increase in quality. And the absence of additional competitors reduces the incentive for existing firms to compete on price, quality, and innovation.

We are not the only ones who recognize this risk to the market. Even supporters of the ballot question recognize this risk. The Boston Globe editorial board, in its stated position article, warned the public about the disparate impact on smaller insurers and the need for further

attention. A primary driver of the ballot question, Dr. Mouhab Rizkallah, stated in a recent DOI listening session that his dentist group had expected carriers may exit the market as a result and that they are comfortable with that result. NABIP would argue that while fewer carriers might benefit the larger carriers, and while it may not negatively impact dentist compensation, this is not an ideal result for the consumers. While voters resoundingly asked for more transparency and administrative cost control, they certainly did not vote for fewer dental options, higher out of pocket claims costs, and higher insurance premiums. To mitigate these results, thoughtful implementation of the law is prudent.

Our Recommendations

The voters of Massachusetts have mandated that the dental carriers better control their administrative costs, and the state can and should certainly implement this. But where costs are not attributable to the carriers, where the carrier has no control, then these expenses should not be considered administrative costs of the carrier, and should be excluded from the loss ratio calculation. Put another way, where costs are not borne by the carriers, where the costs are essentially pass-through costs, these should not be considered part of a carrier's controllable administrative expenses. This would include, but perhaps is not limited to, the following:

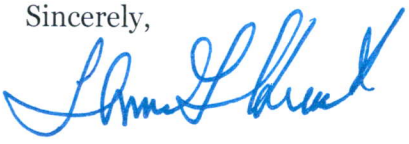
- **Premium taxes**: This is a pass-through item at approximately 2-3%. The tax is set by the state, it is paid entirely to the state, and it can be changed by the state. It is a rate that is uncontrollable by the carriers and therefore should not be considered part of their controllable administrative costs.

- **Benefits Broker Commissions**: These are a pass-through item as well, with little control by the carrier. Carriers may suggest a standard rate between 3-10% of paid premium, with average about 5%, but generally brokers can negotiate this rate with their clients and request the amount to be collected by the carrier and then transferred to the broker. These costs are very different from a carrier's internal sales costs, which are certainly part of a carrier's own administrative expenses. In contrast, broker commissions are costs paid by the employer to an independent broker for services including marketing to various dental carriers, benchmarking plan designs, implementing the plans, educating all employees, maintaining compliance of the plans under ERISA, HIPAA and other laws, managing service issues during the year as well as managing/negotiating renewals. Broker compensation is directly disclosed each year to its clients pursuant to federal law, outside the carrier relationship. The carrier's role is simply one of payment convenience, in that it collects the amount each month from the employer and passes it along to the broker. If an employer doesn't pay in a given month, the broker does not receive its fee. Again, this is very different from a carrier's own carried internal sales costs which are certainly part of its own administrative costs. Broker commissions are another cost that the carrier has little control over, that it simply passes on to a third party (like taxes to the state), and thus it should not be considered part of a carrier's own administrative costs.

- **Timing:** The law as written becomes effective for plan years beginning Jan. 1, 2024. We believe that the authors of the ballot question and employers didn't understand the process of developing rates for the following plan year in the traditional environment. This year is very different from normal times. The Division responsible for drafting, soliciting comment, and finalizing the regulations to operationalize the law. And because Massachusetts is the first state to enact a minimum loss ratio for dental insurance, we are setting a precedent that may serve as a road map for other states (remember the Commonwealth's landmark healthcare reform and its impact on federal reform a half decade later). It is imperative that the Division give itself time to complete this process thoughtfully.

Again, we thank the Division of Insurance for providing the opportunity for NABIP – MA and other interested parties to provide oral and written comments on the implementation of this law. If you have any questions about our comments, please feel free to reach out to us at your convenience.

Sincerely,



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UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

March 30, 2023

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Re: United Concordia Insurance Company
Comments with respect to Chapter 287 of the Acts of 2022
(An Act to Implement Medical Loss Ratios for Dental Plans)
M.G.L Chapter 176X

Dear Mr. Beagan and Ms. Butler:

As a national dental insurance company with a small membership presence in Massachusetts, United Concordia Insurance Company (United Concordia) offers these comments in response to the Information Session questions posted by the Division of Insurance. We understand that responses to these questions will help guide the Division as it develops the regulations required by M.G.L Chapter 176X.

As it develops these regulations, United Concordia encourages the Division to recognize that dental plans are vastly different from medical plans. Most states have not enacted dental loss ratio standards and Congress explicitly exempted dental plans from the loss ratio standards under the Affordable Care Act (ACA). There are important reasons for this that the Division should consider when exercising its regulatory discretion to assure that the regulations developed under Chapter 176X are not duplicative or unnecessarily burdensome to dental insurers or to the Division of Insurance.

The ACA overhauled how medical insurance was offered and thereby increased enrollment for participating health insurers, but it did not do the same for dental insurance. Other than the limited pediatric dental requirement, essential health benefits do not include dental services. In addition, the ACA standardized medical plans offered on the Exchange by setting their actuarial value at certain levels ("metal levels"), creating a level-paying field for medical insurers. Although adult dental can be sold on the public Exchanges, it does not permit tax credits and plans do not have standardized actuarial values. Dental plans also do not benefit from the risk adjustment, reinsurance, or risk corridors measures the ACA implemented to promote market stability.

The result is that there is a great variety of dental plan designs available at many different price points. Despite the benefit and premium variations, these dental products all require a similar degree of administration and most of the same operational and regulatory costs as medical plans. Like medical plans, dental plans must provide member service call centers, maintain provider networks, conduct utilization review and fraud investigations, among other administrative requirements, all of which are labor intensive but contribute to high quality insurance products. Because annual dental plan premiums cost, on average, only 1/20th of medical premiums[1] the proportion of premium spent on administration is much higher in dental plans than in medical plans. For dental plans, administrative expenses can exhaust up to 30% of the premium, and this expense is rising with the ever-increasing scope and burden of regulation.

In addition, the group dental insurance market, unlike the medical insurance market, consists of a large proportion of voluntary plan offerings. This means that the employees enrolling in the plans, not the employers, pay the premium. Even for employers that contribute to the cost of dental premiums, the trend has been to shift more cost to employees to manage the rising cost of employee benefit programs. According to research conducted by the Society for Human Resource Management in 2015, 77% of organizations saw increases in their medical care costs, and 24% of these had an increase of 16% or more[2]. Yet national trends show annual dental premium changes that range from decreases of 0.5% to increases of only 1.5%. Dental insurance does not contribute to the skyrocketing cost of health care. Rather, it is the medical care cost increases that result in pressures on organizations to cut employee benefit spending or shift costs away from their dental plans and other benefits to maintain employee medical plans. As premiums rise and dental plan enrollment declines, consumers will be less likely to get dental care.

We encourage the Division to recognize the operational similarities and vast revenue differences between dental plans and medical plans and to exercise discretion whenever possible to mitigate the market disruption that Chapter 176X is likely to cause. The regulations should allow dental carriers the flexibility to commit appropriate proportions of premium to plan administration, to maintain premiums at their historically low rate, and to ensure a healthy level of competition between carriers. We are concerned that overly restrictive regulations supporting the 83% loss ratio could have the unintended consequence of reducing competition in the dental benefit market by forcing out small insurers like United Concordia and driving consumers to drop their dental insurance coverage. The Division should protect low dental plan premiums and ensure access to dental coverage, promoting the dental and physical health of all consumers in the Commonwealth.

With this background in mind, we offer several suggestions below in response to some of the Division's questions:

Session 1 Definitions Chapter 176X § 1

Question: Is the term "dental benefit plans" understood or do certain terms in the definition need clarification? Should the Division clarify that the definition only applies to

[1] Source: 2019 NADP Financial Operations and Premium Report: Monthly dental PPO premium for large group is $28.70/month; small group is $30.71/month. Kaiser Family Foundation Employer Health Benefits Survey reported annual premium for an individual with an employer sponsored policy at $7,188/ year, $599/month.)

[2] Society for Human Resource Management, 2016 Health Care Benchmarking Report, November. 2016.

insured dental benefit plans and not self-funded plans? Should the Division clarify that the definition does not apply to non-insurance products such as dental discount plans? Is the term "stand-alone" understood or does it need further clarification? Should the Division clarify that health plans with dental benefits incidental to the plan benefits are to be considered stand-alone plans? Should the Division consider plans with more than dental benefits to be considered a "stand-alone" plan if the dental benefits represent a substantial proportion of the plan benefits?

Response: United Concordia Dental recommends that the Division further clarify that the definition of "dental benefit plans" applies only to fully-insured dental benefit plans, and not to those that are self-funded, or are otherwise non-insurance products, such as dental discount plans. While we note that Section 4 of Chapter 176X provides in relevant part: "This chapter shall not apply to dental benefit plans issued, delivered or renewed to a self-insured group…..," we believe additional language in the definition of "dental benefit plans" would provide for added clarity. While the term "stand-alone" has consistent meaning in the dental insurance industry today, it would be valuable to establish more clarity around the inapplicability of these requirements to medical plans with embedded dental benefits and other plans for which dental coverage is incidental to other coverage.

Question: Are there other items within the law that should be defined or clarified? There do not appear to be any definitions of the following terms which are used in the Section 2 of M.G.L. c. 176X: *Medical loss ratio; Underwriting; Auditing; Actuarial Financial analysis; Treasury and investment expenses; Marketing and sales expenses; Advertising; Member relations; Member enrollment; Expenses associated with producers, brokers, and benefit consultants; Claims operations expenses; Adjudication and Appeals; Expenses associated with paying claims; Financial administration expenses; Marketing and sales expenses; Distribution expenses; Claims operations expenses; Medical administration expenses; Disease management; Care management; Utilization review; Medical management activities; Network operations expenses; Charitable expenses; Group product base rates; Group rating factors; Administrative expense loading component; Dental services consumer price index; Contribution to surplus; Direct premiums earned; Realized capital gains and losses; Net income; Accumulated surplus; Accumulated reserves; Risk-Based Capital Ratio.*

United Concordia recommends including a definition for dental loss ratio that appropriately recognizes the differences between medical and dental plans. United Concordia is concerned that the 83% loss ratio standard will not be achievable if dental carriers are restricted from including certain adjustments related to spending on dental care in the numerator and from removing certain components from premiums in the denominator. Chapter 176X provides the Division with the discretionary authority to further define these items to help ensure a stable dental insurance market in the Commonwealth.

Dental plans provide value to consumers by investing a portion of premiums in developing stronger networks with deeper discounts, delivering patient protections against fraud, waste and abuse, investing in quality improvement activities that promote patient care, educating and incentivizing consumers to use their benefits more efficiently, providing sophisticated web tools, online provider directories and pre-treatment cost estimators that increase transparency. Dental plans must budget for such activities with a much smaller premium than medical, often resulting in a lower MLR.

Given the concerns with the capability of some dental plans meeting the 83% standard, the Division should look toward comparable federal and state laws regulating medical insurance – including the Affordable Care Act – and adopt areas that promote a stable dental market for the benefit of consumers.

Below is United Concordia's recommended formula for calculating a dental loss ratio which is similar, but not identical to the ACA medical loss ratio formula.

Formula for Calculating a DLR
NUMERATOR: Spending on Dental Care (Dental Claims) plus Quality Improvement Expenditures, and Expenditures on Fraud, Waste and Abuse Detection
DIVIDED BY:
DENOMINATOR: Earned Premiums less Taxes, Licensing Fees, Regulatory Fees, and Broker Compensation

Important considerations related this formula and loss ratio definition include the following:

- **The Numerator (i.e. spending on dental care):**
    - The Division should include an adjustment for activities that improve dental care quality. This will promote dental plan spending on quality improvement activities and continued patient access to quality dental care. When determining the scope of permitted quality improvement spending, the Division should also recognize that dental care is delivered differently than medical care, with a heavy focus on preventive services. The ACA identifies allowable quality initiatives all of which should be considered. These include, among several other items, activities that improve health outcomes (e.g. quality reporting, case management, care coordination, health assessments); activities to improve patient safety (e.g. effectiveness of best clinical practices, evidence-based medicine, information technology) and activities to implement wellness and health promotion activities. United Concordia also recommends that allowable spending activities include dental care access and network maintenance considering the importance of dental networks in delivering preventive dental services.
    - Related to quality, the numerator should also include an adjustment for spending related to fraud, waste and abuse (FWA) prevention activities. Although the ACA limits the numerator to claims recovered through FWA, United Concordia recommends the inclusion of all spending on activities related to FWA, especially considering the higher administrative costs to overall premium for dental plans. FWA prevention is a critical function of insurers, promotes quality care, contributes to consumer savings and helps control dental care costs.
- **The Denominator (i.e. premiums):**
    - Similar to the loss ratio calculation under the ACA, premiums should exclude federal and state taxes and licensing and regulatory fees.

- Broker compensation should be removed. Similar to federal and state taxes, broker commissions are added to dental premiums after the premium rate is calculated. Broker commissions are treated as a pass-through expense because they are a fee agreed to between the employer group and the broker, and are not determined by the dental carrier. They are the obligation of the employer but for administrative ease are added to the premium bill and passed from the employer through the dental carrier to the broker. We encourage the Division to recognize the essential role of brokers in delivering dental benefits to employers, educating employers and their workers on their dental coverage choices and then servicing the products they choose. Unlike the ACA, there are not insurance exchanges or navigators to replace these agent and broker services. United Concordia is concerned that if dental plans are not permitted to exclude commissions from premium, the pressures to reduce commissions to decrease the denominator will drive brokers out of the dental insurance market, shrinking carriers' distribution channels and reducing the valuable services that brokers provider to employers today.

- **Other Administrative Expenses**

  - Chapter 176X § 2(b) identifies administrative cost expenditures for purposes of calculating the dental loss ratio. The Division has discretion under this section to determine if certain items should be excluded from the list. As explained above related to quality improvement and consistent with the ACA, activities such as disease management, case management, utilization review and other dental management services should be included within the permissible quality improvement activities that are an allowable adjustment to spending on dental care. In addition, activities to maintain dental care access and network maintenance should also be considered an appropriate adjustment to spending on dental care. Distribution expenses related to broker compensation should also be eliminated. Finally, we recommend that charitable expenditures be removed from the denominator.

- **Other Considerations**

  - **Credibility Adjustments.** Similar to the ACA credibility factors, the definition of dental loss ratio should include methodologies, such as de minimis exemptions or credibility adjustments, to account for the special circumstances of smaller plans. A credibility adjustment should be included to address dental plans with low enrollment because smaller plans have more variability in annual claims, making it more difficult to achieve the 83% loss ratio.

  - **Rolling Three Year Average.** Also similar to the ACA, the definition of dental loss ratio should indicate that the loss ratio and any required rebate is calculated based on a three-year rolling average, to accommodate for market volatility.

  - **Market Segment:** Chapter 176X does not distinguish the 83% loss ratio by market segment. United Concordia recommends to the Division that dental carriers should report one loss ratio that represents all dental business (individual,

small group, large group combined) in the Commonwealth. This is especially important for smaller dental carriers with limited enrollment where, absent any credibility adjustments, it would be very difficult to achieve an 83% loss ratio if it was applied separately by market segment. Similarly, any required rebates should be calculated and administered across all lines and market segments.

Session 2 Policy and Rate Filings Chapter 176X § 2(a) – (c)

Question: Is it clear that that the Commissioner of Insurance has the authority to review and approve insured dental benefit policies? Are all insured dental benefit plans "being proposed to individuals and groups" to be submitted to the Division of Insurance for review and approval in order to be offered on an after January 1, 2024? Does this apply only to insured dental plans that are issued in Massachusetts? Does this apply to certificates of coverage given to Massachusetts residents through an employer plan, group trust or group association that is located in another state or jurisdiction?

Response: The language in Chapter 176X § 2(a) indicates that the Commissioner "may approve dental benefit policies". It does not otherwise indicate "shall" or use the word "review". Therefore, this section clearly provides the Commissioner with the discretion to determine whether dental benefit policy approval is warranted under Chapter 176X. However, we are confused by the Division's question as we understand that dental insurers already submit dental benefit policies to the Division for approval pursuant to other separate statutory requirements. Those policies that have already been reviewed and approved by the Division should not have to be resubmitted for reapproval. Considering the other extensive rate and financial filing requirements under Chapter 176X, the imposition of another new filing requirement would only add to the administrative burden and expense imposed by this law upon dental carriers and the Division, without any specific additional benefit to consumers.

Should the Division further address its discretion related to the approval of dental benefit policies in the regulation, we strongly recommend that the scope only extend to policies issued within Massachusetts. Applying benefit standards to certificates issued to Massachusetts residents through groups located outside of the Commonwealth (i.e. extraterritorial application) could create an insurmountable administrative burden on both dental carriers and the Division, again without any specific benefit to Massachusetts consumers. Furthermore, applying the requirements of Chapter 176X on an extraterritorial basis would require dental carriers to adjust multi-state products and processes to the regulatory standards.

The Division should also not assert extraterritorial application to the loss ratio standard and reporting requirements. Adding the loss ratio standard to an extraterritorial requirement would create additional administrative complexity, confusion and eliminate the accuracy of a loss ratio calculation, thereby diminishing any value in the use of such a standard. Approximately thirty-one other states exert jurisdiction over rate filings and establish standards for determining that premiums are reasonable in relation to benefits. Extraterritorial application of the loss ratio standard would likely result in an unreconcilable difference in the rate evaluation process.

Massachusetts would also become an outlier among states if it were to assert extraterritorial application to loss ratio standards and reporting for dental products. Applying a loss ratio standard to these products would be unworkable and erode the accuracy and value of Massachusetts specific data. Clarification would be required regarding how the Division would

measure a loss ratio for dental products that include members residing out-of-state state when cost of care, utilization, and access patterns are different than within Massachusetts.

The most recent state to address dental loss ratio requirements, Maine, recognized these concerns and, rather than implementing loss ratio standards, instead established reporting requirements for policies sitused in the state (see ME S.P. 417 - L.D. 1266 of 2022). We urge the Division to take the same approach as Maine.

Question: Is it clear that that the Commissioner of Insurance has the authority to require carriers to submit information about current and projected loss ratios, as well as projected administrative and financial information with sufficient detail to reflect the items that are identified in the first items (i)-(iii) in this section. Should this information be collected as part of all dental rate filings? Are there any other filings that should include these expenses?

Response: United Concordia agrees that the language in Section (b) provides the Commissioner with the authority to require carriers to submit information about current and projected loss ratios and projected administrative and financial information. However, specific to the submission of projected information, United Concordia recommends that the Division use its discretion in this section to limit the submission to only those circumstances where projected administrative expenses would result in exceeding the defined loss ratio. We also recommend that any such information be collected as part of the rate filing, rather than through a separate filing which will assist in eliminating any additional administrative burden and expense with multiple filings.

Question: It is noted that the medical loss ratio calculations identify the second set of items (i)-(x) as administrative expenses. However, in the first set of items (i) – (iii), the first item (i) identifies "underwriting, auditing, actuarial, financial analysis, treasury and investment expenses" as administrative expenses, which are not listed among the second set of items (i) – (x) that are considered administrative expenses and not to be factored into calculation of loss ratios. Should the first item (i) also be identified as administrative expenses for the calculation of loss ratios? Are there other administrative expenses that are not delineated under the second set of items (i) – (x) that should also be identified as administrative expenses for purposes of calculating a loss ratio?

Response: See our response under **Session 1 Definitions** related to the definition of dental loss ratio.

Question: Should there be separate filings for different markets? For example, should there be separate filings for products offered to individuals, small groups, medium size groups and large groups? Should there be different filings for different product designs (e.g., open network, preferred provider, and closed network)? Should there be different filings for products with different network sizes, different benefit designs or different provider reimbursement (e.g., capitation and fee-for-service)?

Response: To retain regulatory consistency across jurisdictions, United Concordia's preference is to for filings to be segmented simply by policyholder type. That is, there should be separate rate filings for the individual market and all group sizes would be included in one aggregate group rate filing.

Question: May carriers make rate filings other than at the noted July 1 period? Under what circumstances are carriers permitted to make other filings?

Response: United Concordia recommends that rate filings should not be limited to July 1 and that dental carriers should be permitted to file for rate changes at any effective date. This permits flexibility in the sales cycle, policy period variations and the imposition of other mandates that may result in rate adjustments.

United Concordia is also concerned about the timeline for initial implementation. Chapter 176X sets a deadline for final regulation development by October 2023, but mandates a July 1 deadline (without a year specified) for the review of rates for plans that are effective the following January. Considering the current status of regulation development, the administrative process to finalize the regulation, and the January 1, 2024 effective date of Chapter 176X, we recommend that the first filing of rates not occur until July 2024. Such a reading would allow appropriate time for implementation, especially considering the significant adjustments required by dental carriers to accommodate the vast filing and reporting requirements required by Chapter 176X.

Session 3 Presumptive Disapproval Chapter 176X § 2(d)

Question: Within the rate filings, how should carriers submit information so that it presents sufficient detail about how total administrative expenses are projected to increase within the filing for comparison with the presumptive disapproval standard? What should be used to identify the dental services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted)? If there is not an index specific to dental services, should a different basket of service costs be used as a proxy for dental service costs? Should the "most recent year's percentage increase" be based on some specific month to month comparison *e.g., November of one year divided by November of a prior year)? Should there be any adjustments made for New England, Massachusetts or Boston metropolitan-area specific costs? Should the Division of Insurance calculate and announce this statistic annually so that carriers can be aware of this statistic when submitting rate filings that may be presumptively disapproved?

Question: Within the rate filings, how should carriers submit information so that it presents sufficient detail about the filed contribution-to-surplus for comparison to the presumptive disapproval standard? In the regulations for merged market health insurance (211 CMR 66.00), there are provisions for different contribution-to-surplus standards for companies who fall below certain financial ratios; should this be considered for the dental insurance rate filings?

Response: United Concordia is concerned with the impact of a presumptive rate disapproval standard that is tied to the Consumer Price Index (CPI) or reported contribution to surplus. It is not clear why these measures are needed in addition to the dental loss ratio standard.

Information regarding the CPI's measurement of inflation related to medical care (including dental) can be found on the U.S. Bureau of Labor Statistics (the "Bureau") website at: https://www.bls.gov/cpi/factsheets/medical-care.htm

According to the Bureau, the CPI measures inflation by tracking retail prices of a good or service of a constant quality and quantity over time. For medical care (including dental services), the CPI tracks consumer out-of-pocket spending on medical care. On its website, the Bureau

indicates that it "recognizes the challenges to pricing health insurance and indicates that even though insurance premiums are an important part of consumers' medical spending, the CPI does not directly price health insurance policies." The Bureau goes on to note that "In a direct approach, we would track the movement of insurance premiums, holding constant the quality of insurance, and use these price relatives to build the Health Insurance index. However, the CPI has been unable to consistently control for changes in quality such as policy benefits and risk factors. Price change between health plans of varying quality cannot be compared, and any quality adjustment methods to facilitate price comparison would be difficult and subjective."

Although the Bureau has developed an indirect approach, the Bureau's comments underscore the concerns with using the CPI as a central measure in the review of base rate changes. Using such a standard misses key elements of premium rate development and a dental CPI is only one element of a dental premium rate. The CPI is not the correct measurement for administrative expense increases and does not account for plan changes in administrative expenses which will increase or decrease with the size of the plan's business. The CPI completely ignores fluctuation in utilization and reliance only on the CPI could result in inadequate rates should utilization spike. There also is no state specific (or region specific) CPI adjustments available. This will result in a disconnect between consumer prices averaged nationally versus those in New England, Massachusetts, or even in different regions within the Commonwealth.

Based on this, we ask the Division to consider factors that would create flexibility within the CPI presumptive disapproval standard and allow for adjustments tied to utilization, geography, and other groupings of service costs. Accounting for these factors with the CPI will allow more precise evaluation of the reasonableness of premium rates.

Similarly, United Concordia is concerned with the contribution to surplus standard of 1.9%. Such a standard is inconsistent with regulator expectations with contributions to surplus to pay claims. In addition to regulating premium rates, the Division undoubtedly must balance the need for competition among carriers that have stable financial outlooks. We request that the Division build flexibility into the regulation by defining "surplus" to exclude amounts necessary to maintain adequate Risk Based Capital calculations and to exclude contributions to surplus that are necessary to account for incurred but unpaid claims during periods of high utilization.

Question: When the Division reviews a filing and believes that the filing does not satisfy a presumptive disapproval standard, how should the Division notify the carrier about this? Should there be a formal notice that the filing has been presumptively disapproved and identifying the basis for the Division's finding? Should the Division immediately schedule a hearing when it believes a carrier's filing does not meet a presumptive disapproval standard? Should the Division provide a limited time for rate calculations to be updated/amended before initiating a hearing proceeding?

Response: United Concordia recommends that the Division notify carriers of a presumptive disapproval and allow time for dental carrier response, correction and any discussion that may be warranted prior to automatically scheduling a hearing. We believe such a process would be more efficient for all interested parties. We also believe this would better serve the interests of Commonwealth residents by promoting revisions during the review process that allow dental policies to be available for sale in the market without the delay of the hearing process.

Question: Should there be a standard refund calculation worksheet that is filed separately from the rate filing that presents information used to calculate potential refunds? Should this calculation look at actual premiums, claims and expenses over a 12-month period? Should this calculation follow federal standards for refund calculation worksheets for individual and merged market health insurance that calculate the loss ratio using experience over a three-year period to develop an average that is used for comparison to the .83 standard? Should the calculation include the adjustments that are permitted within the federal refund calculation worksheets for individual and merged market health insurance? If there are rate filings for separate markets (e.g., individual, groups of 1-50, groups of 51-100), should there be separate refund calculation worksheets for each of these markets?

Response: United Concordia recommends that the refund calculation factor in actual premiums, claims and expenses over a 12-month period, starting with January 1, 2025. Much of the pricing for 2024 will have been completed prior to finalization of the regulation and therefore could not have accounted for the new minimum loss ratio.

United Concordia also recommends that the calculation follow federal standards that calculate the loss ratio using experience over a three-year period to help to normalize market volatility that could impact a shorter time period.

Specific to a separate refund calculation by market, United Concordia recommends that an individual calculation can be separate, but that all group sizes should be combined.

Question: When should this calculation worksheet be filed with the Division of Insurance so that it might include all relevant claims runout and retroactive adjustments?

Response: United Concordia recommends a three-month run-out period and the ability to apply the appropriate completion factors.

Question: Should there be an implementation plan filed with the refund calculation worksheet that documents the way that a carrier will notify all affected individuals and groups and process the appropriate refunds? Should the implementation plan specify the way that the carrier will follow up with impacted individuals/groups who are not reachable at the location that the carrier has on file? Should the regulation allow carriers to have de minimus standards so that they are not required to refund amounts to individuals/groups that fall below the de minimus level? Should the Division of Insurance have the authority to disapprove any plan that does not meet the statutory timelines or does not adequately distribute/credit refunds to members? Should carriers be penalized (e.g., with interest penalties) for refunds that are not properly transmitted to members within the statutory timelines for refunding premiums to members?

Response: United Concordia supports the establishment of a de minimis standard at both the individual level and the group/employer level. This would be consistent with the ACA which also establishes a de miminis amount below which refunds or rebates on future premiums need not be issued. In establishing de minimis standards, the Division should consider the increased administrative burden resulting from the mandated notices and the process of cutting manual checks or implementing future rebates within complex general ledger systems. While issuance of any rebate or refund drives up administrative expense, refunding amounts that fall below a de minimus level will result in increased administrative expense to carriers without value to the recipient. The Division should also make clear in the regulation that for the group market the

refund shall be sent to the employer for further distribution to its employees and that the dental carrier obligation ends upon distribution to the employer.

Further, United Concordia urges the Division to establish regulations that do not penalize carriers when they are found to be acting in good faith to meet the statutory timeframe for issuing refunds.

Question: Section 2.(f)(i), indicates that the communication should go to all employers and individuals covered under a group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance; should this communication also go to individuals covered under an individual product when that product's rate increase has been presumptively disapproved? When coverage is through a group association/trust product, should there also be a notice to the association that covers the groups/members? Are there any concerns about carriers having information regarding correct contact information to send these notices to individuals? What method should be used to deliver the notice to groups and individuals? Are notices to be forwarded by mail, e-mail or other method? Should the notices be reviewed by the Division of Insurance prior to their being sent to groups and individuals? How long after the carrier has been notified that a rate filing has been disapproved should the carrier send the notices to members?

Response: United Concordia is concerned with the requirements of this section related to the requirement to notify to individuals covered under a group product. In the group market, the carrier's customer is the employer or association (policyholder) and communications from the carrier are distributed to the policyholder, which passes these to their covered employees or participants, as appropriate. United Concordia recommends that the Division clarify that the expectation is communication to the policyholder, be it in the group or the individual market, not to all members participating in a dental plan. Further, United Concordia recommends that notices of presumptive rate disapprovals only be issued to policyholders to which the carrier has already proposed rates that would be impacted by the disapproval. If the carrier has not issued any proposed rates subject to the disapproval, then no notices should be necessary. This would serve to incentivize carriers to gain the Division's approval before using a proposed rate and also to minimize disruption to policyholders and members/participants.

Further, it is not clear why this notification process for presumptive rate disapproval would not align with the notification process for premium refunds. Rates are established between the carrier and the group policyholder (employer/association), and refunds will be sent to the group policyholder. The carrier does not determine what, if any, proportion of the premium is contributed by each member/participant. That decision is made by the group policyholder. Because the impact of rate changes and rebates is determined by group policyholders for their individual members/participants, it should be the group policyholder that receives the notification. United Concordia encourages the Division to recognize established communication channels between carriers and policyholders and should permit carriers to deliver the notices in the same manner as which they would generally communicate with their groups. To create efficiencies in the process and help carriers keep administrative expenses low, the Division should also consider permitting the required notices to be posted on carriers' websites since these are accessible by all consumers and such changes to websites can be made quickly and at little cost.

Session 4 Financial Reporting Chapter 176X § 3

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

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

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

Response: United Concordia is concerned with the narrow reporting tiers identified in this Section. Dental carriers do not track data in these tiers and reporting by this level of segmentation is not feasible and will render the data non-credible. Such data would not be usable or appropriately represent costs and expenditures. United Concordia's preference would be to follow the reporting tiers for the medical MLR filings, which only include reporting by individual, small group and large group (over 50).

United Concordia recommends that enrolled lives be utilized for reporting purposes. Enrolled lives are an accurate representation of the underlying expenses associated with each group.

The Division should utilize its discretion in determining which expenses are reported by market segment. Many of the categories listed cannot be directly attributed to a line of business or by group size (realized capital gains and losses, accumulated surplus, accumulated reserves, risk-based capital ratio, charitable expenses, board, bureau or association fees, payroll expenses).

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

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

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

Response: United Concordia notes that this provision alone will increase administrative costs as dental carriers will be obligated to devote substantial time and technology investments to adjust accounting systems to these unique reporting requirements that currently don't exist within the industry.

Section 3.(e) and (f) - "If, in any year, a carrier reports a risk-based capital ratio on a combined entity based under subsection (a) that exceeds 700 percent, the division shall hold a public hearing within 60 days. The carriers shall submit testimony on its overall financial condition and the continued need for additional surplus. The carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the carrier will dedicate any additional surplus to reducing the cost of dental benefit plans or for dental care quality improvement, patient safety, or dental cost containment activities not conducted in previous years. The division shall review such testimony and issue a final report on the results of the hearing."

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

Question: Are there any items that require additional clarifications?

Response: Risk Based Capital (RBC) is already reported to the Division on a combined entity basis. According to the National Association of Insurance Commissioners (NAIC) the purpose of RBC is to identify weakly capitalized companies to help ensure timely regulatory intervention. It's an important tool used by regulators to assess financial solvency. United Concordia is concerned that reliance on the 700% RBC threshold related to surplus ignores other important factors that the Division should consider when determining the appropriate surplus. For example, the Division could also consider other factors including:

- Carrier business volume - is it growing or shrinking.
- The carrier's ability to raise surplus.
- The carrier's ability to decrease surplus (via dividends to its shareholders or other means) to manage to a prescribed level.
- The types of insurance products offered by the carrier. Certain products or business lines are much more volatile and require greater surplus levels than less risky, more predictable products or business lines.

These are just some of the complexities that must be carefully considered in any financial reporting public disclosures and Chapter 176X does not otherwise recognize the many differences between the types of insurance entities that offer dental coverage. For example, different factors would impact the financial condition of a small regional single line carrier versus a national multi-line carrier. Because of these complexities, it's important for the Division to consider the intended goal of the RBC threshold related to financial solvency and whether other metrics such as the loss ratio standard already achieve those goals more directly.

Based on these considerations, United Concordia recommends that in assessing the scope of testimony for the hearings, that the Division recognize the variability of situations encountered

by different carriers to avoid benefiting some carriers and penalizing others through the RBC metric.

Section 4 - "Except as otherwise provided below, this chapter shall apply to all dental benefit plans, including plans issued directly by a carrier, through the connector, or through an intermediary. This chapter shall not apply to dental benefit plans issued, delivered or renewed to a self-insured group or where the carrier is acting as a third-party administrator. Nothing in this chapter shall be construed to require a carrier that does not issue dental benefit plans subject to this chapter to issue dental benefit plans subject to this chapter."

Question: Are there any items that require additional clarifications?

Response: United Concordia's position is that the language in Chapter 176X § 4 clearly excludes from the Chapter self-insured groups and all TPAs that administer self-insured dental benefit plans. Chapter 176X § 3(c), relative to reporting requirements for TPAs, includes language that cannot be read consistently with Section 4 of the Chapter. Section 3(c) obligates only those carriers providing administrative services to self-insured groups to include an appendix to the financial reporting that includes certain information regarding the carrier's self-insured customers. Yet a plain reading of the language in Section 4 excludes those same carriers from any obligation under the Chapter.

Because Section 4 was drafted to specifically address application of the entire Chapter, Section 4 should control how other sections of the Chapter are interpreted to apply to TPAs. A reasonable conclusion is that Section 3(c) must be interpreted as unenforceable in lieu of the clear exclusionary language in Section 4. We therefore recommend that the Division use its discretion to remove from any regulatory requirement supporting Chapter 176X financial reporting by carriers serving as TPAs or by entities licensed only as a TPA. This position is also supported by Federal case law where the United States Supreme Court has ruled that state-based reporting requirements related to self-insured employer plans are not enforceable and are preempted by ERISA (see Gobielle v. Liberty Mutual).

We appreciate your consideration of United Concordia's comments. Please do not hesitate to contact me should you have any questions or require additional information.

Sincerely,

Bernard J. LaPine
Director, Regulatory and Legislative Affairs
United Concordia Dental

April 20, 2023

The Honorable Gary D. Anderson
Commissioner
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Dear Commissioner Anderson:

Thank you for the opportunity to add to the record of the Division of Insurance's information sessions on implementing new M.G.L. Ch. 176X. This letter reflects comments from the Life Insurance Association of Massachusetts, the American Council of Life Insurers, the National Association of Dental Plans and America's Health Insurance Plans, referred to infra as "carriers."

LIAM is a trade association that represents 23 of the nation's leading life, long term care, disability and dental insurance carriers. In addition, many of our members also offer family and medical leave plans and retirement plans. The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental Indemnity and discount dental products to 200 million Americans with dental benefits.

We urge the Division of Insurance to proceed deliberately and cautiously as you develop regulations pursuant to Ch. 176X. The new law contains various provisions which carriers fear may raise the price of dental insurance as well as disrupt the existing dental insurance market in the Commonwealth. We believe that it is important for the Division to use your discretion to mitigate these potential negative consequences – particularly for consumers – as you contemplate the implementation if Ch. 176X.

Dental insurance is important to Massachusetts residents' oral and physical health -- particularly for those with lower incomes.

According to the American Dental Association, having dental insurance coverage contributes to better dental and overall health. They note, however, that more and more adults are experiencing increased financial barriers to care.

> *"Dental care-seeking behavior is strongly associated with having dental benefits."*
>
> *"Individuals with dental benefits are more likely to have visited the dentist in the last year and go to the dentist for preventive care than those without benefits."*

"Financial barriers and not knowing how much treatments cost are the two most common reasons for delaying dental care."

In Massachusetts almost all dental insurance is issued to employer groups. According to Milliman (a leading independent actuarial firm), dental insurance is a popular employee benefit.

"Out of the portfolio of benefits offered by employers to employees and their families, dental insurance is one of the most highly valued benefits by workers. When dental benefits are available, 68% of employees participate in the plan, second only to medical coverage."

According to the National Association of Dental Plans, dental benefits are relied on more heavily by consumers with lower incomes.

"In Massachusetts, 44% of consumers covered by dental benefits have an annual household income of less than $50,000."

A major concern for carriers is the potential market dislocations caused by the dental loss ratio itself. This concern was also voiced by a group of experts. The 2014 Special Commission on Dental Insurance – made up of legislators, executive branch officials, business community representatives, insurers, dentists, health care advocates and other interested parties – considered a number of dental insurance proposals. The Special Commission hired an outside consultant to conduct a comprehensive review of the relevant dental care marketplace and used quantifiable data obtained through independent survey and analysis.

After careful consideration, the Special Commission rejected the notion of requiring dental plans to meet minimum loss ratios**.** The Commission expressed concern that setting minimum loss ratios would make it unprofitable for dental insurers to offer coverage in the Commonwealth, making dental insurance more expensive and driving carriers out of the market here. Today, carriers continue to share this concern.

Ch. 176X presents a dilemma for carriers. One of the purposes of loss ratio imposition is to limit the percent of premium that can be spent on administrative expenses. Yet, the new law potentially imposes significant new administrative cost burdens as described below. We urge you to avoid increases in administrative expenses whenever possible as you implement this new law. The imposition of an 83% loss ratio for these low-premium products leaves no room for unnecessary administrative expense increases.

In order to meet the 17% limit on administrative costs imposed under the law, carriers will likely need to make changes to their systems that will be unpopular with providers and their patients and will require support from policymakers to implement. For example, current systems that allow for the convenience of a dentist or member to receive verification of benefits or pretreatment estimates telephonically are much more expensive than self-service portals. Requiring other electronic methodologies versus paper (e.g. requiring electronic submission of all claims, appeals and supporting materials, removing paper and other more expensive payment options, electronic EOBs) will also allow for administrative savings but have proven to be unpopular with some dentists and patients in the past.

Creating barriers to dental care and to consumer and provider-friendly administrative services in Massachusetts will be detrimental to consumers' oral and general health and is bad public policy.

We urge the Division to carefully consider higher prices, market disruption and barriers to care in all your regulatory decision making regarding implementation of Ch. 176X.

We offer the following thoughts for how to mitigate duplication and administrative burden, while recognizing the unique aspects of dental insurance and the insurers that deliver these products.

CH. 176X, SECTION 3 – ANNUAL FINANCIAL STATEMENT AND DATA REPORTING SCOPE AND GRANULARITY

The purported goal of section 3 of the new law is to provide transparency in the costs of the administration of dental insurance. To accomplish this the Division should not promulgate regulations that add to those costs. Section 3(f) allows the Commissioner to waive specific reporting requirements for classes of carriers for which he/she deems such reporting requirements to be "inapplicable," meaning not relevant, appropriate or suitable.
The language presented in section 3 is a copy-and-paste of the repealed reporting requirements in M.G.L. C. 176O, §21. Only a year after its initial enactment, 176O was amended to remove dental plans from the statute's reporting requirements. In 2018, the statute was again amended – this time completely repealing the Ch. 176O, section 21(a) reporting requirement for all carriers. The repeal was in recognition that these reporting requirements did not provide useful information and failed to promote transparency in health care. They were also highly burdensome to all parties involved.

Many of the reporting requirements in section 3 have elements that are duplicative and unnecessarily add to carriers' administrative costs. First, some of the information is already collected by the Division in the annual statement every carrier files. Second, additional prospective financial information such as information related to administrative expenditures will already be collected under the rate review process. While the need for transparency is important, the Division should reduce instances of duplicative, redundant or surplus reporting requirements that only increase administrative burdens and costs.

The reporting requirements under section 3 are not related to review of loss ratio or the rate review process established in section 2 of the law – the regulations should reflect this distinction and should not treat section 3 reports as supporting section 2 filings. Further, the data collected should be limited to that needed to comply with the statute. Such restraint will still promote transparency without overly burdening both carriers and the Division with the need to collect, report, analyze and manage unnecessary data.

Requiring segmentation of reporting requirements by market segments or other micro-segments that are not normally tracked or reported in such a granular manner in any reporting or rate filing process will undermine the goal of improving transparency. To over-segment data -- as suggested by some stakeholders -- would require arbitrary allocation methods that do not reflect the actual budgeting that occurs within dental insurers that offer multiple products and would jeopardize the legitimacy of the data and only further obscure costs and expenditures.

Risk-based capital reporting

As part of the annual financial statement required under section 3, carriers must report risk-based capital based on a formula developed by the National Association of Insurance Commissioners. New Ch. 176X does not, however, recognize the many important distinctions between the types of insurance entities that offer dental coverage in Massachusetts. There are complexities to the financial reporting, solvency requirements, and administrative and delivery functions of the different types of insurers offering dental coverage that must be carefully considered in any loss

ratio or financial reporting public disclosures. Section 3(f) gives the Commissioner discretion as to how this provision is appropriately applied. While existing regulations on risk-based capital are differentiated by the type of coverage offered by a carrier, they do not account for the diverse range of carriers that participate in the Massachusetts dental benefits market. Without careful consideration, the implementation of chapter 176X could cause significant confusion across insurance products.

Risk Based Capital must already be reported to the Division every year. The RBC calculation was specifically created so that it must be reported on an enterprise-wide basis. It was created to signal to regulators that the assets held by an insurer are at risk of not being adequate and appropriate to support liabilities. It is solely intended as a measure of solvency. The new regulation should recognize this purpose as much as possible given that the new law requires the state to use RBC as a proxy for excessive reserves.

There may be inconsistent or misleading results for insurers depending upon the type of entity they are or the amount of business they have in Massachusetts versus other states. A company with 100% of MA dental business versus a company with 1% MA dental business and 99% business in other lines of insurance and other states will have RBC that appropriately look very different because the amount of capital included in RBC relates to the legal entity, not a specific state. Different types of insurers must use different reporting forms and structures with different factors that recognize their differences in structure, reserve requirements, access to capital. The implementation of this regulation should reflect that.

The capital calculated using the applicable formula in the NAIC RBC model referred to as Company Action Level (CAL) capital should be applied to plans that have the majority of their liabilities in non-dental or non-Massachusetts insurance lines. This is the capital amount that should be compared to total adjusted capital in calculating an RBC for purposes of determining whether the 700% trigger in MGL Chapter 176X, section 3(e) is met.

We are also concerned that there are inconsistencies and misinterpretation risks for those insurers that have the bulk of their liabilities in non-dental or non-Massachusetts business. We therefore suggest that the Commissioner use the discretion afforded by this law to exempt insurers with less than 10% of their total risk-adjusted liability in Massachusetts dental insurance.

In order to assure that RBC can still be used appropriately as a measure of reserve adequacy, we recommend that for multi-line carriers with RBCs, as calculated under 211 CMR 20, below 300% for the four most recent consecutive quarters then group base premium rates will be disapproved if the contribution to surplus is higher than 2.5% as opposed to the 1.9% for all other carriers. This will assure that carriers that have low reserves are able to bring their RBC to a more appropriate level. For health and dental-only carriers in the state, we recommend aligning the requirements with existing regulations on RBC reporting at 211 CMR 25.

Self-Insured and TPA Reporting

It is clear that this law and the reporting requirements it imposes are not applicable to self-insured employers nor to the third-party administrators that administer their benefits.

Section 4 expressly exempts carriers acting as TPAs from the requirements of the new law:
"Except as otherwise provided below, this chapter shall apply to all dental benefit plans, including plans issued directly through a carrier, through the connector, or through an intermediary. ***This***

chapter shall not apply to dental plans issued, delivered or renewed to a self-insured group or where the carrier is acting as a third-party administrator."

Section 4 is clear by its plain reading: Ch. 176X does not apply in circumstances where a carrier is acting as a TPA. Thus, Section 3(c), relative to reporting requirements for TPAs, cannot be read consistently with Section 4 and is thus rendered moot and unenforceable. Given this, the Division should exercise its authority to waive reporting requirements for carriers acting as TPAs under section 3(c).

Moreover, this interpretation is supported by the United States Supreme Court's decision in Gobeille v. Liberty Mutual which held that plans acting as third-party administrators under ERISA are broadly exempt from state reporting requirements under ERISA's preemption clause. ERISA pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U. S. C. §1144(a). The Court struck down Vermont's health claims database reporting requirements which also applied to dental benefits. In striking down the law, the Court stated that it imposes duties that are inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements.

If the Division considers requiring the reporting of TPA information, it will need to accommodate for the fact that carriers do not have access to information relative to premiums charged by self-insured plans, nor do they have enough information to accurately determine a loss ratio on these plans. A carrier would also not be able to determine the plan's net income, accumulated surplus nor reserves. Further, a carrier could not accurately break out this information relative to their own income, surplus or reserves from the administrative fees charged to the self-insured plans.

FILINGS, RATE REVIEW, RATING FACTORS/BASE RATES, REFUNDS

The statute establishes a process for carriers to submit rates for review when they are establishing or making changes to group rating factors or base rates. We strongly recommend that market participants be allowed to utilize their existing group rating factor calculation methodology consistent with industry standards. Adoption of a finite set of permissible group rating factors may be inconsistent with existing carrier group factor methodology and require administrative changes to existing processes that will result in additional administrative expense. The division should properly permit any actuarially sound rating factor, including those statutorily permitted, unless it is expressly prohibited or deemed unfairly discriminatory. Organizations create their administrative expense allocation and accounting systems to best suit their business needs across all lines of business and depending on the types of reporting they must do to various internal and external organizations. Standardizing this allocation across insurers will require massive internal system changes that will by highly disruptive to their entire business and will increase administrative expenses significantly.

Importantly – base rates should not be construed to mean premiums charged. As is the industry standard, base rates are the claim value based on a specified plan design.

While we agree that there are provisions of the "merged market" methodology, established by MA DOI for non-dental products, that can serve as a model for currently non-existent dental rate filing requirements, we caution against imposition of the "merged market" methodology for purposes of actual rate calculation. Because the merged market methodology would require an administrative adjustment to existing rate calculation processes, application of a new calculation methodology would ultimately add to the cost paid by the consumer. Merging of individual and small group risk

pools for low-premium products like dental will increase the likelihood of certain employers seeing intolerable rate increases.

We do not believe that the law supports or requires the merging of the individual and small group markets for purposes of filing of rates. Since there is already a proven system for filing of individual rates, we believe that it is more effective to have individual and group rates filed separately with new group rate filing requirements mirroring the individual rate filing processes where applicable to group.

Dental loss ratios should be reported in aggregate across all plan types and group sizes because the law sets forth only one required loss ratio percentage (83%) to be applied to all products and markets. Had the law identified more appropriate loss ratio levels to reflect the differences in administrative costs for different group sizes, it would be appropriate to report loss ratios by group size. However, since the law only identifies one loss ratio required for all market segments, it is important that issuers be allowed to aggregate their loss ratio report across all plan types and group sizes. There is only one dental loss ratio level identified and required in the new law, even though individual and group markets have different administrative costs. Therefore, carriers should report one loss ratio level that represents all of their dental business including individual and group in aggregate.

Consistently, there should not be separate refund calculations per group size. In segregating the loss ratio reporting, the division would risk lower-premium products from meeting the statutory requirements. Refunds due to an individual policyholder should be paid to the individual policyholder and refunds due to a group policyholder should be paid to the group policyholder, not each individual certificate holder. Since only one dental loss ratio amount is allowed, any required rebates should be calculated and administered across all lines and market segments of a carrier's dental business.

When reviewing refunds, the division should consider the administrative cost of issuing the refund and establish a de minimis standard for refunds. Dental is a low-premium product, especially in comparison to medical. In many instances refunds to members will be extremely low – often lower than the administrative cost of issuing the refund. Rebates below the de minimis standard should be waived as is allowed for loss ratios on ACA medical coverage.

The authority under this statute should be limited only to the review of group product base rates and changes to group rating factors. Individual filings should be exempted from this review process as they already undergo separate review at the Division. Currently, individual filings include the claim base rate, administrative components, and an actuarial memorandum. These filings should be consistent with how the companies write their business and thus should only be filed at the product level.

Where applicable, the Division should minimize duplicative filings, and should review any items that may be proprietary or confidential, using their exam authority if necessary. Carriers can submit the necessary information through SERFF, but that information should be limited to the items necessary for review. The filing requirements should not introduce novel administrative costs to deal with a Massachusetts specific form completion and at most adopt what's required in other states, for example use of a rate manual with carrier's pre-existing format.

Rate filings should not necessarily be limited to July 1 – the sales cycle, multiyear contracts, and the authority of other applicable statutes for the plan or carrier should also be considered.

DENTAL LOSS RATIO DEFINITION

The passage of this ballot question represents a first-in-the-nation law that has the potential to decrease dental coverage availability and increase the cost of coverage. Given this, the Division should look toward comparable federal and state laws regulating medical insurance – including the Affordable Care Act – both for areas that have worked to the benefit of consumers and those that have not. Careful consideration of the differences between medical and dental is also critical. Implementation of this new law requires creation of a definition of "Dental Loss Ratio" that takes into account the unique differences between dental insurance and medical insurance.

Medical insurance is mandated by both Massachusetts and federal law, whereas dental insurance is a voluntary purchase. Differences extend to the delivery of care, with dental insurance focused on preventative care – in contrast to medical's curative model. Such differences in focus should be factored into the quality improvement and outcomes portion of the dental loss ratio equation. Due to the preventive focus, dental insurance premiums are significantly lower than medical insurance premiums, however the administrative functions and requirements are similar to medical. Because dental insurance has not been under loss ratio requirements, many dental plans are not currently calculating their spending on care improvement activities to a level of detail necessary to report them for loss ratio calculation. Therefore, a robust definition of these activities will be critical for plans to meet dental loss ratio requirements.

Here are some general recommendations related to the implementation of the loss ratio requirements in the law:

The Commissioner should consider instituting "credibility adjustments" (similar to the ACA standards at 45 CFR §158.230) to account for those carriers that have a small book of dental business or very small numbers of Massachusetts residents in their membership. We would recommend the current ACA credibility threshold be applied to this law. For medical insurance, the ACA deems that carriers with less than 1,000 member-years or 12,000 member months in a state are deemed in compliance with ACA MLR requirements in that state. The ACA deems such membership levels "non-credible" for purposes of MLR calculation and we believe this standard is applicable to dental as well. Therefore, carriers with less than 1,000 member-years or 12,000 member-months in Massachusetts dental business should be deemed in compliance with the MLR requirements set forth in this new law.

Dental loss ratios should be measured on a rolling 3-year average, again to assure credibility of the data used to calculate the loss ratio. The substantial disruption of the COVID public health emergency provides a good example of an event that caused a major shift in utilization and loss ratio levels. A three-year average as suggested can partially mitigate that risk.

To ensure patients continue to have access to high quality dental care the Division should permit the inclusion of activities that are intended to improve dental care quality in the loss ratio formula's numerator. The inclusion of quality initiatives in the DLR formula will provide consumers assurances that dental insurance is focused on care quality and improvement, and also recognize the differences between the medical and dental care while working within an existing regulatory framework. Much like their use in the medical space, dental quality initiatives will encourage equitable access to dentistry, preventive care, disease management and the use of the adoption of technologies that will enhance a modern and digital dental experience for patients. Adopting quality initiatives not only assures patient benefit, but also permits flexibility in a modernizing insurance space as it moves toward a value-based system.

We encourage the Division to look to the metrics and standards established by the Dental Quality Alliance for additional guidance, especially those associated with the integration of care. For example, these measures include:

- Percentage of enrolled adults aged 30 years old and older with history of periodontitis who received comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year
- Number of emergency department visits for ambulatory care sensitive dental conditions per 100,000 member-months for enrolled adults
- Percentage of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation with the reporting year
- Percentage of ambulatory care sensitive dental conditions emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the emergency department visit

These and other metrics are established to measure the effectiveness of value-based care designs in dental coverage. Plan activities aimed at improving these metrics are designed to improve the quality of care provided to dental patients.

Section 2(b) gives the Commissioner the discretion to determine what shall be deemed an administrative cost expenditure for the purpose of calculating the dental loss ratio.

- Taxes and assessments should be excluded from the DLR calculation in recognition of the fact that they are outside the control of the carrier.
- Broker compensation should likewise be excluded from the DLR calculation. Dental insurance is most often presented to employers as part of the overall financial protection offerings available. It is vitally important that insurers be allowed to remunerate brokers for their work of educating employers and their workers on their dental coverage choices and then servicing the products they choose. For non-pediatric ACA dental coverage, there are not insurance exchanges or navigators to replace these agent and broker services. Additionally, broker fees are sometimes "pass through" expenses, the obligation of the employers themselves but passed through the dental insurer for convenience-sake.

Here is our recommended definition of "Dental Loss Ratio"

1. *Dental loss ratio defined. For purposes of this section, the dental loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively. For purposes of this subsection:*

    (A) The numerator is the sum of:

        (i) The amount expended for clinical dental services provided to enrollees as defined in rule in accordance with section 3;

        (ii) The amount expended on activities that are intended to improve dental care quality as defined in rule in accordance with section 4; and

        (ii) The amount of claims payments identified through fraud reduction efforts.

    (B) The denominator is the total amount of premium revenue, excluding federal and state taxes and licensing and regulatory fees paid and after accounting for any payments pursuant to federal law; fraud prevention activities; and excluding agent

and broker compensation or pass-through payments. The numerator described in paragraph A may not include administrative cost expenditures as defined in rule, except as noted in paragraph B.

2. Expenditures for clinical dental services. "Clinical Dental Services" are services performed by a dental practitioner for the diagnosis or treatment of dental illness or injury or the prevention of disease and maintenance of oral health. Such expenditures include any payment to a provider, not just direct care cost.

3. Activities intended to improve dental care quality. Activities conducted by an issuer intended to improve dental care quality must meet the following requirements:

(A) The activity must be designed to:

(i) Improve oral and/or physical health quality;

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

(iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non- enrollees; or

(iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(B) The activity must be primarily designed to:

(i) Improve oral or physical health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;

(a) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

(1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives

(2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based dental care

(3) Quality reporting and documentation of care in non-electronic format

(4) Health information technology to support these activities

(5) Accreditation fees directly related to quality-of-care activities

(6) Commencing with the 2024 reporting year and extending through the first reporting year in which plans adopt updates to the Clinical Dental Terminology code set, limited to 0.3 percent of an issuer's earned premium

(b) Support programs to encourage patient adherence to preventive care regimens including but not limited to:

(1) *regular oral exams and professional cleanings*
(2) *fluoride treatments*
(3) *oral self-care education*

(4) Health information technology to support these activities.

(ii) Improve patient safety, reduce clinical errors, and lower infection comorbidity rates.

(a) Examples of such activities include:

(1) The appropriate identification and use of best clinical practices to avoid harm.

(2) Activities to identify and encourage evidence-based dental care in addressing independently identified and documented clinical errors or safety concerns.

(3) Activities to lower oral infections and comorbidities.

(4) Activities to support use of personal health equipment and infectious disease prevention techniques.

(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce clinical errors.

(6) Health information technology to support these activities.

(7)(i) For DLR reporting years before 2024, actual rewards, incentives, bonuses, and reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market ;

(ii) Beginning with the 2024 DLR reporting year, actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims;

(8) Coaching or education programs and oral health promotion activities designed to change member behavior and conditions (for example correct brushing, regular flossing, recognizing oral health problems); and

(9) Health information technology to support these activities.

(v) Enhance the use of health care data intended to improve quality, transparency, and outcomes and support meaningful use of health information technology.

(C) Exclusions. Expenditures and activities that must not be included in quality improving activities are:

(i) Those that are designed primarily to control or contain costs;

ii) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

(iii) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;

(iv) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(v) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of DCT code sets, except as provided for in section 3(B)(i)(a)(6) above.

(vi) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve oral health quality;

(vii) All retrospective and concurrent utilization review;(vii) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(viii) Provider credentialing;

(ix) Marketing expenses, except as provided for in section 1(B) above.

(x) Costs associated with calculating and administering individual enrollee or employee incentives;

(xi) That portion of prospective utilization that does not meet the definition of activities intended to improve health quality; and

(xii) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Commissioner, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

OTHER TERMS NEEDING DEFINITIONS OR CLARIFICATION

Section 2d:

"Administrative Expense Loading Component." The phrase is taken directly from Chapter 176J, Section 6 for health insurance. Absent the reference to Dental CPI, we interpret this as the expense component of the premium rate. However, by limiting the change to Dental CPI (and Medical CPI for health plans), it seems to imply this is the claim component of the premium rate. If this is supposed to represent administrative expense component, it is not clear what the tie is to Dental CPI.

"Carrier's Reported Contribution to Surplus." We believe this term should be interpreted to be the profit component of the premium rate, limited to Massachusetts dental business. We believe that the Dental Services CPI is the appropriate of the various CPI choices to use, with the caveat that CPI itself is not an accurate reflection of administrative costs, but rather it measures service cost

changes. However, given that the law requires measurement off of CPI, we request that if a Contribution to Surplus (profit) is negative, the carrier should be able to increase base rates at a level in excess of Dental CPI.

Section 3a:

We believe that "market group size" should be determined based on enrolled lives versus eligible lives.

PROPRIETARY INFORMATION & PRIVACY

For any reporting requirement, the Division should keep confidential any information reported that is proprietary to the business – such as the administrative fees charged to self-insured plans or components of group rating factors. Where possible, the division should exempt such information from the state's public records law.

TIMELINES

Rate filings should not necessarily be limited to July 1 – the sales cycle, multiyear contracts, and the authority of other applicable statutes for the plan or carrier should also be considered.

We are concerned about the timeline for initial implementation – carriers need clarity about expectations over the next year while this is being developed. We urge the Division to issue guidance spelling out carriers' interim compliance requirements.

Given the statute's requirement for Fall regulations with no specific year upon which the Fall filing requirement is to begin, we believe it is prudent that the first filing for rates should be in July 2024. This reading would allow appropriate time for correct implementation of regulation, without question of what information and form would be required for compliance. The Division could issue guidance that puts carriers on a path for compliance without mandating rate filing this year. Additionally, given the number of different filings that may be required depending on how an entity is regulated elsewhere, we urge the Division to avoid duplication and unnecessary administrative expense in its receipt and review of filings.

Again, thank you for the opportunity to provide these comments.

Sincerely,

Owen Urech
Director of Government & Regulatory Affairs
NADP

Amanda Herrington
Executive Director
AHIP

Cindy Goff
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May 5, 2023

Deputy Commissioner Kevin Beagan
Massachusetts Division of Insurance
1000 Washington Street
Boston MA 02118

RE: Requested comments on Division of Insurance regulations concerning Chapter 287 of the Acts of 2022/M.G.L. c. 176X

Dear Deputy Commissioner Beagan:

Blue Cross Blue Shield of Massachusetts (Blue Cross) appreciates the opportunity to submit comments to the Division of Insurance (the Division) regarding Chapter 287 of the Acts of 2022, codified as Chapter 176X of the Massachusetts General Laws. We appreciate the Division's thoughtful approach to gain input from stakeholders and evaluate the new law prior to undertaking a formal regulatory process. This critical and detailed work in advance of the Division's promulgation of regulations will ensure clarification of Ch. 176X that supports patient care and best practice.

Blue Cross' priority is the implementation of a dental loss ratio (DLR) that furthers the affordability, accessibility, and quality of dental care for our members and employer customers. We believe that there are two fundamental principles that should be prioritized in the regulation drafting process:

- Any new regulatory structure should be drafted with the aim of benefiting the dental insurance-buying public.
    - Consistent with this goal, the principles of affordable access to preventative dental care and oral health should be prioritized.
    - Care should be taken to ensure that consumer disruption (including the negative consequences of larger market disruption) is minimized, and consumers can continue to have strong options for affordable and high-quality dental insurance products in Massachusetts.
- Whenever possible, established regulatory policy and practice should be leveraged as foundational bellwethers for the regulatory structure.
    - Key learnings, for example, from the Division of Insurance's long-established medical loss ratios, related regulatory reporting, rebate structures and guidelines, and rating rules should be used to inform the development of final regulations since these have worked to minimize consumer disruption and provide structured consumer benefits.
    - There are already tested models in use in other Division of Insurance regulations and filings that provide strong guidance for new DLR standards.
        - Much can be learned from the state's highly precise medical loss ratio (MLR) rebate standards as foundational to building new DLR regulations on this same point.
        - Moreover, the Division of Insurance should closely examine its large group market regulatory filing structures as model for rate filing processes, since this market is very similar to the dental insurance rating structures.

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Introductory Scope: Consistent with these foundational principles, we respectfully present the following detailed suggestions. At the outset, we refer to and incorporate herein our previous letter of January 31, 2023. As the Division adopts regulatory guidance in this precise area, it is important to note that it is one in which Ch. 176X allows for significant regulatory discretion. Similar discretion was previously evidenced within 211 CMR 147, *Methodology for Calculating and Reporting Medical Loss Ratios* (MLRs) *of Health Benefit Plans*, which defines MLR as, "the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums, according to current NAIC methodology and with reference to federal guidance, or as otherwise determined by the Commissioner." As noted more fully below, the Division would do well to adopt a regulatory approach consistent with this discretion in two key areas: administrative expenses and claims expenses.

Dental Rate Filings: While the parallels between the merged market's MLR and DLR definitions are clear, the same is not true for the intended filing structures. Dental filings do not have guarantee issue requirements as a matter of law, there is no individual coverage mandate, nor minimum coverage or actuarial value requirements. Unlike the merged market in health care, carriers are not required to offer identical plans and benefits to all accounts and individuals who wish to purchase coverage or use block-rating; rather, carriers may and do exercise underwriting judgment in the dental insurance market. These are relevant and material market differences.

Accordingly, for the purposes of the rate filing structure, we urge the Division to look to a market much more aligned with dental insurance, specifically as found within 211 CMR 43. Dental rate filings are most like the large group health insurance commercial business requirements, which include an actuarial filing that demonstrates a carrier's methodology, data, and assumptions for developing a manual base rate for one standard plan design. In practice, this manual base rate will be used by a carrier's underwriting department to develop rates for individual accounts.

- An account's rate will vary depending on account benefit design; account claims experience; credibility of account's experience; and, length of account renewal (1-year rate, 2-year rate, etc.).
- Base rate should be determined using an actuarially sound method determined by each carrier.
- The historic dental loss ratios included in the rate filing are for informational purposes only. DLR rebates will be determined by the separate DLR filing. The projected loss ratios reported in the rate filing are also for informational purposes only and will not be relied upon to determine rebates in the market. The final filed loss ratio will depend on actual claims and premium, not projections.
- The listed components of projected administrative expenses and financial information should be clarified and made consistent so that the same list of administrative components is used for both the loss ratio filing and the rate filing. This will allow for comparisons between the two separate filings - one historical and the other projected.
- As in large group, the Division should allow flexibility in rating methodology and in the content of rate filings, provided that it is actuarially sound.
- The rating factors allowed in the dental market should be the same as those in the large group commercial insured market: account size, geographic region, age, participation, industry, and tiering factors.
- This increase in administrative expense component should be calculated as that of the base rate compared to the prior year's actual administrative expenses, as included in the most recently

submitted DLR filing, and then annualized to be on the same basis as the United States Bureau of Labor Statistics Consumer Price Index for Dental Services.

- Industry standard should inform clarification of a carrier's reported contribution of surplus and calculation of aggregate loss ratio.

Furthermore, it should be noted that the Division's usual and customary practices and current regulations reinforce the principle that the promulgation of regulations is a prerequisite to making rate filings. Ch. 176X assumes that carriers will make filings in accordance with the Division's regulations. In the absence of regulatory direction, carriers would not know what materials the Division would require in order to review a rate filing.

- Ch. 176X utilizes a familiar structure by which it directs a regulator to promulgate regulations by a certain date and then imposes requirements on regulated entities pursuant to those regulations.
- Ch. 176X contemplates that the Division will require a substantial amount of time to promulgate the necessary regulations, and that carriers will then submit substantial amounts of information to the Division pursuant to the regulations.
- Ch. 176X does not provide a basis to conclude that there should be any deviation from this very common regulatory process. As such, the Act is best understood to require rate filings beginning July, 2024.

Standardized Reporting: Ch. 176X charges the Division with establishing "criteria for standardized reporting" and consultation "with other agencies of the Commonwealth and the federal government and affected carriers to ensure that the reporting requirements imposed…are not duplicative." We encourage the Division to examine existing requirements and resources, as well as the existing MLR structure and process that is well-established in Massachusetts.

Specifically, while the law makes mention of an Annual Comprehensive Financial Statement (ACFS) tool, its use has been terminated (in 2019) due to a flawed methodology that would result in misinterpretations and a false sense of the market. If used here, that same intrinsic flaw will result in consumer hardship since it will provide information not reflective of actual market dynamics and practical realities for the dental insurance market. We urge the Commissioner to exercise the authority outlined in Ch. 176X, sec. 3F, to "waive reporting requirements", and instead use reporting consistent with that of MLR reporting. Additionally, reporting should be based on calendar year coverage periods not policy periods – this is an approach consistent with prevailing market practice.

Consistent Rebate Methodology: Lastly, we strongly urge that DLR refund requirements be set in a manner that allows their calculation and administration as provided under MLR, as set forth variously in 211 CMR 66, 211 CMR 147, Affordable Care Act regulations, and the consistent methodology established by the National Association of Insurance Commissioners (NAIC). Specifically:

- Calculations should reflect all group sizes and plans under same line of business for a carrier.
    - Similar to the ACA and states where dental loss ratio is calculated statutorily, the Division should utilize experience over a three-year reporting period whereby an average is used for comparison to the 83% standard, which will help reduce market volatility to the consumer's benefit.

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  - Similar to MLR, rebates should be calculated in the aggregate across all Massachusetts market segments for a carrier so as not to have a disproportionate impact on specific markets (eg, the difference between the group and individual markets). Rebates should be proportional to each group or individual dental policy's earned premiums for the applicable coverage period.
- Consistent with MLR:
  - The DLR calculation's numerator should include claims incurred and expenditures on quality improvement activities during the coverage period January 1 to December 31 each year (known as of March 31 the following year).
  - The DLR calculation's denominator should include earned dental premiums during the calendar year coverage period January 1 to December 31, and not use earned premium during the policy year, which aligns with other statutory filings. Further, it should deduct federal and state taxes, assessments, and licensing and regulatory fees. Rebates issued should not be reduced from the premium revenue in the subsequent year.
- There should be a creditability adjustment to the calculation based on membership volume application to prevent volatility.
- Further, rebates or credits should only be issued to a group policy holder or subscriber for individual policies since carriers do not have the ability to issue rebates to subscribers of group policies due to lack of contribution rate information. A "de minimus" standard should be included within the regulations so that carriers may apply for a waiver from the rebate requirements if the levels are below a certain amount.

As the Division considers the practical implementation dates for filing and rebate deadlines, it should be mindful of avoiding the identical filing dates as those that exist for health rate and MLR filings. Since the same functional work will be performed with plans for both, duplicate timelines would strain internal and Division resources.

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In closing, I wish to note our appreciation for the Division of Insurance's detailed and transparent regulatory process. As always, we pledge to work with you to the mutual goal of protecting consumers as you implement a dental loss ratio regulatory structure that furthers the affordability, accessibility, and quality of dental insurance options for our members and employer-customers.

Sincerely,

Michael T. Caljouw
Vice President
Government & Regulatory Affairs

cc: Commissioner Gary Anderson