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January 30, 2023

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Massachusetts Division of Insurance
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Re: Altus Dental Insurance Company, Inc.
Comments With Respect To "Definitions";
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 (First) Informative Session conducted on January 18, 2023, we respectfully submit the following comments with respect to Section 1 – "Definitions" – of newly enacted M.G.L. c. 176X. We understand that the Division is seeking input from stakeholders in connection with future regulatory guidance with respect to the statute.

The Significance of A Well Considered Definition of "Dental Loss Ratio"

We note at the outset that M.G.L. c. 176X was enacted without any actual definition or calculation for "Dental Loss Ratio" – or even "Medical Loss Ratio". The Chapter includes (in Subsections 2 and 3) carriers' *reporting* obligations to the Division with respect to certain types of "administrative expenses", but is silent with respect to which of those expenses are – or are not – excluded from the Dental Loss Ratio and corresponding calculations.

This is significant in that medical or dental loss ratio models that include every conceivable item of administrative expense (*i.e.*, models that calculate the ratio purely as incurred claims divided by earned premiums) usually fix the ratio itself at a much lower percentage. The newly enacted Dental Loss Ratio regulation in New Mexico (13 NMAC 13.10.35) is such a model. The Dental Loss Ratio it establishes is 65% (for Vision plans it is 55%), a stark contrast to the 83% established by M.G.L. c. 176X. To our knowledge no other Dental Loss Ratio has ever been established that high.

Nor, to our knowledge, have any Medical Loss Ratios ever been established at that high end of the scale *that have not involved a litany of expenses being excluded from the ratio calculation methodology*. Implementation of such a high end ratio without exclusions historically universally applicable to Medical Loss Ratios would impose substantial disproportionate and unfair hardship on dental plans. It would compound the already fundamentally unfair imposition of high end loss ratio requirements to dental plans (as if they were medical plans) *even with* such exclusions. Dental plans do not cover hospitalizations or catastrophic claims, and usually involve annual maximum benefits of a few thousand dollars or less, and average premiums are generally one fifteenth or less than medical plans. Yet dental plans still incur expenses for the same functions as medical plans, including but not limited to claims processing and adjudication, financial administration, general administration, utilization review, quality of care management, network operation expenses, payroll expenses, and state and federal taxes, assessments, and licensing fees. High end loss ratio requirements are thus much more difficult for dental plans to meet. Hence, substantial care and attention is called for in the definition and calculation of the dental loss ratio itself, something that c. 176X has effectively left to the Commissioners.

The NAIC / ACA Model's Exclusion Of Certain Expenses From The Medical Loss Ratio Definition / Calculation

Notably, in 211 CMR 147.00 ("Methodology For Calculating And Reporting Medical Loss Ratios (MLRS) Of Health Benefit Plans"), the Division reserved substantial discretion with respect to the definitional measurement and calculation of Medical Loss Ratios, and provided for substantial deference to NAIC and federal guidance. The regulation defines "Medical Loss Ratio" flexibly as follows (§ 147.02):

> "MLR. Medical Loss Ratio, which is 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."

Similarly, c. 176X itself recites that, "The Commissioner shall adopt rules to carry out this subsection, including … criteria for the standardized reporting and uniform allocation methodologies among carriers. The division shall, before adopting regulations under this section, consult with other agencies of the Commonwealth and the federal government and

affected carriers to ensure that the reporting requirements imposed under the regulations are not duplicative."

When the federal Patient Protection and Affordable Care Act (the "ACA") was enacted, it required the NAIC to establish uniform definitions and standardized methodologies for calculating them as Medical Loss Ratios that have become an industry regulatory standard, at least with respect to "medical" plans. The methodology deducts from the premium a number of categories of expenses. They include federal and state taxes, assessments and fees, as well as incurred medical incentive pool expenses and bonuses, and costs related to improving health care quality and fraud reduction. Certain of those expenses – most notably federal and state taxes – are excluded from administrative expenses in the annual loss ratio filings Altus is already required to file with the Division on Exchange products.

All of these types of expenses should be included in the Dental Loss Ratio definition and measurement calculation that implements c. 176X. In addition to taxes, they should include as claims costs direct payments made to dentists in the form of value and quality based care bonuses, as well as direct subsidies to dentists and dental practices for equipment, including but not limited to personal protection equipment or hygienist expense and/or training.

"Pass-Through" External Brokers And Consultants' Commissions Should Be Excluded From The DLR Calculation

The Division should also recognize that there are certain types of payments that dental plans make that are merely "pass-through" expenses that comprise obligations of the plans' customers – not the plan – and have nothing to do with the administration or operation of the plan itself. Chief among these are fees or commissions incurred by the customer with external brokers that are the customer's obligations under separate contracts, but that are billed in a "pass-through" manner as essentially a courtesy. Altus does not have brokers. These pass-through external broker/consultant commissions should under no circumstances figure into the dental loss ratio, as they have no bearing on the value proposition that medical and dental loss ratios represents, *i.e.*, the proportion that payments for health care bear in relation to the expenses and profits the health plans *themselves* experience for providing that service.

Should you desire additional information on this issue, Altus would be pleased to provide it, including how the inclusion of even just federal and state taxes and external broker commissions as part of administrative expenses for dental ratio calculation purposes would mostly evaporate the 17% of revenue remaining after imposition of an 83% dental loss ratio, leaving next to nothing with which to operate the business.

More specifically, small group commissions (under 60 subscribers) are generally around 10%, whereas for small group medical they are approximately only 2%, the latter being driven by the above-referenced fact that on average, external medical insurance premiums are approximately fifteen times greater than dental insurance premiums. Approximately 85% of

Altus' total client base involves groups between 5 and 59 subscribers, where the average annualized external broker commission or fee is 9.5%, and groups between 30 and 59 subscribers, where the average annualized external broker commission or fee is 8.0%. If that sum were included in the Dental Loss Ratio together with the Massachusetts 2.28% premium tax, that would leave only 5.4% with which to operate the 5 – 29 subscriber small group category, and only 6.8% with which to operate the 30 – 59 subscriber category. With respect to larger groups over 100%, a minority of Altus' total client base, the average annualized commission or fee payments reduce slightly, but the same issues exist. It would be impossible to realize any reasonable administrative fee component to run the business.

Suggested Definition Of "Dental Loss Ratio"

In consideration of the foregoing, our sample/suggested definition of "Dental Loss Ratio" is as follows:

> **"Dental Loss Ratio"** means incurred claims divided by earned premiums where
>
> (a) *"incurred claims"* means, for a reporting year, the claims for which services were provided in the reporting year, including an estimate of unpaid claim reserves and incurred value based care incentive pool and bonuses; direct subsidies to dentists and dental practices for equipment, including but not limited to personal protection equipment or hygienist expense; costs related to improving health care quality, access or fraud reduction; direct subsidies or contributions for equipment, facilities, or otherwise to non-profit entities for services to the underserved population, or for educational or training expenses for hygienists; and
>
> (b) "*earned premiums*" means, for a reporting year, the premium received for coverage provided during the reporting year minus federal and state taxes and assessments; and external pass-through brokers' or consultants' commissions or fees for which the group or individual receiving coverage is effectively responsible.

Definition of "Carrier"; "Self Insured Group"; "Third Party Administrator"

- Although it is already explicit in Subsection 4 of c. 176X that the Chapter does *not* apply to dental benefit plans issued, delivered or renewed to a "self insured group" or "third party administrator", the definition of "carrier" should, for good measure, include the word "insured" before "dental benefit plans".

- For the same reason, the word "only" should be added after the words "administrative services" in the definitions of "self insured customer" and "third party administrator".

• Finally, as the Division may be aware, MIIA and similar organizations or Trusts operate such that losses are funded by member municipalities. However, under many such arrangements, the member groups (*i.e.*, municipalities) are provided with a guaranteed rate. At that level, because the rate is guaranteed, the plan should be deemed "insured" as opposed to "self insured" and should be subject to the provisions of c. 176X. Evasion of those obligations would lead to unfair advantages; defeat or diminish the overall transparency purposes of c. 176X; and de-stabilize the market as a whole.

Definition of "Dental Benefit Plans"

• The Division should clarify that the definition of "Dental Benefit Plans' applies only to "insured", Dental Benefit Plans and not to non-insured products such as dental discount plans.

• The term "stand-alone" in the definition requires clarification. If dental benefits are bundled or otherwise included in a health plan under the same contract or certificate they should be separately reported on and rated in accordance with the Dental Loss Ratio standards. Otherwise carriers that offer both medical and dental plans arbitrarily manipulate/re-allocate dental coverages to medical/hospital plan coverages having much higher claims experience, thus evading Dental Loss Ratio requirements; distorting the rating process; and creating unfair competitive advantages that will de-stabilize the market as a whole.

• It should be clarified that the various descriptors in the "Dental Benefit Plans" definitions in c. 176X (*i.e.*, "oral surgical care", "dental services", "dental procedures or benefits") are "and/or" descriptors, lest they be interpreted as requiring *all* of the descriptors in order for a plan to be a "Dental Benefits Plan" subject to c. 176X. The chapter should cover "*any insured plan that covers in whole or in part oral surgical care, and/or dental services, and/or dental procedures or benefits*".

Thank you for this opportunity for Altus to comment with respect to 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

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January 31, 2023

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

RE: Chapter 287 of the Acts of 2022
An Act to Implement Medical Loss Ratios for Dental Benefit Plans
Information Session #1, January 18, 2023 - Section 1: Definitions

Deputy Commissioner Beagan:

Thank you for the opportunity to submit comments to the Division of Insurance (DOI) regarding Section 1 of Chapter 287 of the Acts of 2022. We are appreciative of DOI'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 will ensure the promulgation of regulations that support and further clarify Chapter 287 so that implementation is successful.

Blue Cross Blue Shield of Massachusetts is committed to working with DOI to identify existing laws, guidance, and processes that can serve as tried and tested models for dental loss ratio (DLR). Much can be learned from the significant work that has been done to fine-tune the medical loss ratio (MLR) construct, which can now be leveraged to mirror that MLR's regulatory structure for DLR.

We encourage DOI to use available resources, such as those listed below, as a starting point for responding to questions posed regarding the definition section of Chapter 287, and recommend the following to support this:

The definitions in section 1 of MGL c. 176J, Small Group Base Rates, should be used as a starting point to define:

- Actuarial Opinion
- Base Premium Rate
- Carrier
- Group Base Premium Rates
- Dental Benefit Plan – See Health Benefit Plan
- Rating Factor

The definitions within 211 CMR 147, Methodology for Calculating and Reporting Medical Loss Ratios (MLRs) should be used as a model to clarify and define:

- Carrier
- Commissioner
- Dental Benefit Plan – See Health Dental Plan
- Dental Loss Ratio – See Medical Loss Ratio
- Third-Party Administrator

The definitions within 211 CMR 66, Small Group Health Insurance, should be used as a model to clarify and define:

- Administrative Expense Standards (including expense loading component,
- Actuarial Opinion
- Benefit Level Rate Adjustment Factor

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- Claims Operations Expenses (includes expense associated with paying claims and appeals)
- Charitable Contributions Expenses Distribution Expenses (includes expenses associated with producers, brokers, and benefit consultants)
- Contribution to Surplus (includes Risk-based Capital Ratio as defined by 211 CMR 25)
- Financial Administration Expenses (includes treasury, underwriting, actuarial, auditing, investment, and financial analysis/investment expenses)
- General Administration Expenses
- Marketing and Sales Expenses (includes advertising, member enrollment, member relations)
- Medical Administration Expenses (includes utilization review, and medical, care, and disease management)
- Dental Administration Expenses – See Medical Administration Expenses (including consumer price index)
- Taxes, Assessments and Fines Paid to Federal, State or Local Governments as Expenses (includes capital gains)

The definitions within MGL c. 176O, sec. 21 regarding Health Insurance Consumer Protections should be used as a model to clarify and define:

- Self-insured Customer
- Self-insured Group
- Third-party Administrator

The definitions within 211 CMR 25, Risk-Based Capital (RBC) for Health Organizations should be used as a model to clarify and define:

- Total Adjusted Capital (including net income)

The definitions used by the Health Policy Commission within MGL c. 6D, sec. 1 should be used as a model to clarify and define:

- Payer (in the context of exclusion of ERISA/self-insured plans due to federal preemption)

The definitions used by the Commonwealth Health Insurance Connector in MGL c. 176Q, sec 1, should be used as a starting point to define:

- Stand-alone Dental Plan

Finally, the American Dental Association's nomenclature and coding should be used to clarify and define dental care, services, and procedural terms.

Again, we appreciate the opportunity to participate in this transparent and effective pre-regulatory process and welcome any questions you may have.

Sincerely,

Michael T. Caljouw
Vice President
Government & Regulatory Affairs

From: Rupp, Peggy K HHHH
To: Beagan, Kevin (DOI); Butler, Rebecca (DOI)
Subject: Comments on definitions for Dental Loss Ratio
Date: Wednesday, February 1, 2023 1:36:14 PM

Hello Kevin and Rebecca
I sent this request through MAHP but wanted to make sure it got over to both of you.

The bill makes reference to 176J for several of the terms in the reporting section, but 176J does not have those definitions and we also checked regulation 211 CMR 66 and couldn't find them. We found some of them in 211 CMR 147.04 but that is specific to large group medical loss ratio. Here are the definitions we need clarified:

Section 3:
(b) (i) direct premiums
(b) (i) direct claims incurred
(c) (ii) aggregate number of members
(c) (iv) aggregate value of direct premiums earned
(c) (v) – aggregate medical loss ratio for self-insured customers - this references medical loss ratio but does it really want dental loss ratio reported?

Thank you.

Peggy Rupp
State Regulatory Manager
IA, MA, ME, MN, OH, NH, RI, VT, WV
614-602-9581

Compliance_Signature_small

2 Willow Street
Southborough, MA 01745

Dear Deputy Commissioner Beagan,

After our initial meeting on the implementation of Question 2, the Massachusetts Dental Society (MDS), representing over 5,000 dentists across the Commonwealth wants to express its support of this process and contributes to the implementation of Question 2 so that it reflects the clear mandate from Massachusetts' residents to have fair value for their dental insurance.

During the initial hearing, several areas of concern were discussed. The MDS will focus its comments on the necessary terminology needing clear definitions in order to enable the implementation of the ballot question. The MDS believes the Division of Insurance should utilize these definitions in the final regulations.

Standalone: There should be no carve-outs for plans that are predominately dental benefit plans that incorporate other benefits (e.g., vision, the example utilized during the meeting). We believe any plan-making payments on Current Dental Terminology (CDT) codes that are not subject to ERISA pre-emption should be subject to the DLR mandate.

Dental Loss Ratio: Only expenditures made by a dental benefits carrier that are related to any CDT code should count toward the Dental Loss Ratio calculation numerator. This allows for substantial flexibility to put toward efforts such as quality improvements. We believe simplification will make it easier for the Division to manage the program and will more likely reflect the expectations of the Massachusetts Public. We, therefore, submit the following definition.

In our review of the Ballot Question 2, we noted that it refers to a definition of "Incurred Claims" from Section 176J where no definition exists. For the purposes of DLR calculation, we would submit the following definition:

Incurred claims are those where the insured event or clinical service has occurred and which the 3rd party payer is liable for payment. The value of all amounts paid or payable under a dental benefit plan, determined by contract to be a liability with an incurred date during the DLR reporting period.

Dental Loss Ratio (DLR) is the proportion of premiums directed toward patient care.

Formula for calculating an Issuer's Dental loss ratio:

(a) ***Dental loss ratio.***

(1) An issuer's DLR is the ratio of the numerator, as defined in paragraph (b) of this section, to the denominator, as defined in paragraph (c) of this section.

(2) An issuer's DLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

(b) ***Numerator:*** The numerator of an issuer's DLR for a DLR reporting year must be the issuer's incurred claims (all claims within the reporting year that are paid or still payable).

(C) ***Denominator:*** The Denominator of an issuer's DLR of a DLR reporting year must be the insurer's Premium revenue. The denominator should not include any deductions for federal and state taxes, licensing, and regulatory fees from the denominator.

Earned Premium Definition: Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the dental plan.

The Massachusetts Dental Society respectfully submits these public comments to support the implementation of the Chapter 287 of the Acts of 2022, "An Act to Implement Medical Loss Ratios for Dental Benefit Plans."

Please email efactor@massdental.org if you have any questions regarding these comments.

ROSEN & GOYAL, P.C.

January 30, 2023

VIA E-MAIL (KEVIN.BEAGAN@MASS.GOV; REBECCA.BUTLER@MASS.GOV)

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

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

Dear Deputy Commissioner Beagan and General Counsel Butler:

I am writing as counsel for and on behalf of Dr. Mouhab Rizkallah DDS MSD CAGS, who filed the initiative petition for Question 2 in 2022. As you know, Dr. Rizkallah is the chair of the Committee on Dental Insurance Quality, which supported Question 2.

Dr. Rizkallah and I attended the January 18, 2023 information session, in which the Division of Insurance (the "Division") solicited feedback concerning the definitions in M.G.L. c. 176X, Section 1, for purposes of developing regulations to implement Chapter 287. Thank you for providing the opportunity to offer guidance on this crucial topic.

To begin with, in any Chapter 176X regulatory language promulgated by the Division, please bear in mind the overall reason why Question 2 was on the ballot to begin with: to expand the medical loss ratio ("MLR") requirements from health benefit plans to dental benefit plans. The MLR requirements for health benefit plans can be found under M.G.L. c. 176J, § 6. Comparing Chapter 176X to M.G.L. c. 176J, §§ 1 *et seq.* ("Chapter 176J"), it becomes apparent that the authors did not intend to reinvent the wheel. Many of the provisions in Chapter 287 are similar or identical to comparable provisions in Chapter 176J (as well as a prior version of M.G.L. c. 176O, § 21).

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In that same spirit, the Division should not seek to reinvent the wheel when it comes to the regulatory definitions for Chapter 176X—or with respect to any other provision of Chapter 176X. That is, adhering as closely as possible to the pre-existing regulatory framework that is in place for health benefit plans will yield regulations that most accurately embody the intent of Question 2. For example, definitions promulgated under Chapter 176J can be found in 211 CMR 147.02 and 211 CMR 66.08. These two regulations alone cover the bulk of the terms that were discussed at the information session on January 18, and should be used as the framework for definitions under Chapter 176X. To the extent that the Division receives requests from any stakeholders (particularly insurers) to promulgate definitions that somehow deviate from the framework laid out for health benefit plans, the Division should consider these requests critically.

With that said, Dr. Rizkallah answers the questions posed by the Division as follows:

1. **Is the definition for "carrier" understood or do certain terms in the definition need clarification? Does this apply to self-funded employer-sponsored dental benefit plans or to any third party administrators that may perform certain administrative tasks for the self-funded plans?**

With respect to the first question: The definition of "carrier" is reasonably understood by virtue of its reference to "dental benefit plans." A "carrier" is defined as an insurer or other entity "offering dental benefit plans," and in turn the various types of "dental benefit plans" are extensively defined. To further elaborate on the definition of "carrier" would be redundant, as it would be effectively listing in detail virtually the same information from the definition of "dental benefit plans." Although some expressed concern at the information session that the phrase "other entity" may be vague, it is not when referencing the definition of "dental benefit plans." For example, it would include (as identified explicitly in the definition of "dental benefit plans") non-profit medical service corporations, dental service corporations, health maintenance organizations, and preferred provider arrangements.

The second question can be answered by reference to Section 4 of Chapter 176X, which provides in relevant part: "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."

2. **Are the terms for "commissioner" and "Connector" understood or do certain terms in the definition need clarification?**

Both terms are reasonably understood as they are defined identically in Chapter 176J, and thus are intended to be equivalent in scope.

3. **Is the term "dental benefit plans" understood or do certain terms in the definition need clarification? Does this include self-funded plans? Does this apply to non-insurance products such as dental discount plans?**

With respect to the first question, the term "dental benefit plans" is reasonably understood. To the extent any further clarification is needed, the Division should look to the definition of "health benefit plan" under 211 CMR 147.02 for guidance: "A policy, contract, certificate or agreement entered, into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services."

With respect to the second question, 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…." In turn, "self-insured group" is defined as "a self-insured or self-funded employer group health plan." Therefore, the definition does not apply to self-funded plans. With respect to the third question, the definition does not apply to non-insurance dental discount plans.

4. **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?**

Although Dr. Rizkallah believes the term "stand-alone" is reasonably understood, the Division may wish to consider further elaboration. The definition of "heath benefit plan" under M.G.L. c. 176J, § 1 expressly exempts "dental benefits if offered separately" from the health benefit plan. Thus, to the extent that any further clarification should be required regarding "stand-alone" dental plans, the regulations should specify that "stand-alone" dental plans are those plans where dental benefits are offered separately from health benefit plans. The Division should not create tests concerning whether dental benefit plans are a "substantial proportion" of plan benefits, or concerning whether dental benefit plans are bundled with other non-health benefit plan benefits, which may unnecessarily complicate the term or inadvertently allow certain carriers to avoid their obligations under Chapter 176X.

5. **Are the terms "oral surgical care", "dental services" and "dental procedures" understood or should any of these be clarified? Are there other dental services, procedures, or supplies that should be identified so that it is clear that they may be covered under what is considered a "dental benefit plan? For example, if an insured dental plan only covers "benefits for dentures", "benefits for orthodontic care/braces", or "TMJ benefits", should that be considered a "dental benefit plan"?**

These terms are reasonably understood and should not be clarified. It bears noting that Division regulations do not further clarify what can be offered under health benefit plans. To do so here would risk narrowing the broad array of services and procedures that a dental benefit plan may offer. In particular, the terms "dental services" and "dental procedures" are broad and would naturally encompass orthodontic care, braces, dentures, and TMJ treatment, among much more.

6. Are there other items within the law that should be defined or clarified?

To the extent that the Division believes it necessary to define the various terms in Chapter 176X that are not provided definitions by Chapter 176X itself, the Division should use 211 CMR 66.08 as a frame of reference. For example, 211 CMR 66.08 provides definitions for "claims operations expenses," "marketing and sales expenses," "network operations expenses," and many more. 211 CMR 147.02 also provides a suitable definition for "Medical Loss Ratio" (i.e., "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."). Regardless of whether or not the Division ultimately promulgates regulatory definitions for such terms, it bears emphasizing that they are intended to be equivalent in scope to the same terms as they appear in M.G.L. c. 176J, § 6.

In conclusion, adherence to the aforementioned guiding principle—that the regulations for Chapter 176X emulate the framework established by Chapter 176J—will best ensure that the Division's regulations faithfully embody both the spirit and letter of the law. We look forward to working with the Division to that end at future information sessions. Please do not hesitate to contact us with any questions or to discuss our comments further. Thank you.

Sincerely,

/s/ Matthew Perry

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c.c. Dr. Mouhab Rizkallah DDS MSD CAGS

2 Willow Street
Southborough, MA 01745

Dear Deputy Commissioner Beagan,

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The Massachusetts Dental Society respectfully submits these public comments to support the implementation of the Chapter 287 of the Acts of 2022, "An Act to Implement Medical Loss Ratios for Dental Benefit Plans."

Please email efactor@massdental.org if you have any questions regarding these comments.