ROSEN & GOYAL, P.C.

February 13, 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:

As you know, I am counsel for the Committee on Dental Insurance Quality (the "Committee"), which supported Question 2 on the 2022 Massachusetts general election ballot. Per the request of the Division of Insurance, this letter constitutes the Committee's written response to questions posed by the Division at the February 1, 2023 information session attended by myself and the chair of the Committee, Dr. Mouhab Rizkallah. We once again thank the Division for soliciting input as it seeks to draft regulations to implement M.G.L. c. 176X.

As I did in my previous letter to the Division, I want to reiterate that the starting point for drafting these regulations should be to refer to the framework already established under M.G.L. c. 176J, as we believe this is the most effective means of establishing one of the key goals of Question 2—that is, expanding the medical loss ratio ("MLR") requirements from health benefit plans to dental benefit plans. With that said, the Committee answers the questions posed by the Division on Sections 2(a) – 2(c) of M.G.L. c. 176X as follows:

SECTION 2(a):

1) **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 and after January 1, 2024?**

204 Andover Street, Suite 402 • Andover, MA 01810
tel: 978.474.0100 • fax: 978-719-6373 • www.rosenlawoffice.com

Yes, the law plainly spells this out. The Committee further wishes to address a comment raised concerning this question at the information session. It was noted that, because the law indicates that the Commissioner "may approve" dental benefit policies, rather than "shall approve," that this provides the Commissioner with discretionary authority rather than a mandatory authority. Although this may be true as far as it goes, further clarification is needed as to what, precisely, is made "discretionary" under this provision of the law. The operative word in this provision is "approve." Thus, it is **approval** of dental benefit policies that is made discretionary.

That is not to say that the discretion afforded by this provision means that the Commissioner may avoid the approval/disproval process for dental benefit policies altogether. Other provisions make clear that the process itself is mandatory—not discretionary. For example, Section 2(b) provides that the Commissioner "shall require" carriers to submit their financial information, Section 2(c) provides circumstances under which the Commissioner "shall disapprove" base rate changes, and Section 2(d) provides circumstances under which base rate changes "shall be presumptively disapproved" by the Commissioner. If carriers were able to avoid submitting their dental benefit policies for approval or disproval, this would conflict with various other mandator provisions of the law and would undermine its purpose.

In any event, M.G.L. c. 176J, § 6(a) likewise provides that the Commissioner "may approve" health insurance policies, so that identical language under M.G.L. c. 176X should be interpreted the same.

2) **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?**

The Division may wish to consult the federal MLR requirements, which provide: "Group coverage issued by a single issuer that covers employees in multiple States must be attributed to the applicable State based on the situs of the contract. Group coverage issued by multiple affiliated issuers that covers employees in multiple States must be attributed by each issuer to each State based on the situs of the contract." 45 C.F.R. § 158.120(b). In other words, for group coverage, what typically matters is where the contract is issued or delivered, rather than where the certificate of coverage is issued. However, the federal MLR requirements have certain exceptions with respect to individual market business sold through an association or trust, as well as employer business issued through a group trust. See 45 C.F.R. § 158.120(d). Otherwise, these issues should be dealt with by the Division in the same way that they are dealt with for health benefit plans under Chapter 176J.

3) **Is it clear that dental carriers may offer insured dental benefit policies that provide benefits through a network of dental providers and may offer products with different provider networks, including those that may be a subset of an existing dental provider network?**

Yes, it is clear.

4) **Should the Division of Insurance (DOI) issue any guidance so that dental carriers prominently identify a product's network and provide any explanation when it may offer different provider networks among its group of dental products?**

The Committee has no objections to the general notion of the Division promulgating regulations on this topic. The Division may wish to use the existing regulations in the health insurance realm under 211 CMR 152.00 *et seq*. as guidance. In particular, requiring dental carriers to clearly market and advertise their plans, like health carriers under 211 CMR 152.06, would be beneficial.

It bears noting that provider networks are not a central focus of M.G.L. c. 176X. Additional provisions, such as M.G.L. c. 176J, § 11, govern provider networks in the health insurance realm that are not included in M.G.L. c. 176X. As a result, to the extent that the Division does adopt any regulations on this topic, they should be more streamlined than those appearing in 211 CMR 152.00.

5) **What eligibility criteria, if any, should the Division consider when adopting regulations?**

Individuals should be eligible if they are a resident of the Commonwealth.

SECTION 2(b):

1) **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?**

Yes, it is clear, and it should be collected as part of all dental rate filings.

2) **It is noted that carriers are to submit projected administrative expenses and financial information, including, but not limited to what is indicated in the first items (i)-(iii). There are many not identified in the first items (i)-(iii) that are in the second set of items (i)-(x). Should those items that are in the second set of items (i)-(x) that are not in the first set of items (i)-(iii) be also included in the detailed projected administrative expenses and financial information?**

Yes. The items in the second set are specified components of the "administrative cost expenditure[s] for the purposes of for calculating **and reporting** the medical loss ratio." These expenses must, therefore, be itemized. If the items in the second set were to be excluded from the

first set, it would not fulfill the prescribed medical loss ratio reporting requirement of Section 2(b). Insurers would then be able to calculate their MLRs without providing a large portion of the data that went into their calculations, which would open the door to manipulation of MLRs without accountability. The term "administrative expenses" before the first list is intended to be the same as "administrative cost expenditure" before the second list. Moreover, it is evident that the second set of items should be included with the first set of items when comparing the language in Chapter 176X to the language of M.G.L. c. 176J, § 6(b) and 211 CMR 66.08(3)(h), which include such items in what a carrier must report.

3) **It is noted that the 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?**

Yes. It becomes evident that item (i) in the first list is synonymous with item (i) in the second list, when referencing the definition of "financial administration expenses" under 211 CMR 66.08(1)(g).

4) **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 the purpose of calculating a loss ratio?**

Any additional administrative expenses not delineated under the second set of items have been left to the discretion of the commissioner, with Chapter 176J providing guidance.

On a related note, during the latest information session, one participant raised the possibility of factoring quality improvement activities (QIAs) into the MLR calculation. While QIAs may have value in medical benefits, the Committee does not believe that QIAs are a valuable part of patient dental benefits, and is merely an effective loophole for insurers. As such, the Committee proposes that QIAs should not be included in the numerator of the MLR at all.

Notwithstanding this, the Committee has no objections to including QIAs, provided that such activities are defined in a way that: a.) limits QIAs to those activities that are performed by and/or performed through providers, rather than the carriers themselves (for increased transparency); b.) do not allow carriers to have a broader scope of QIAs factored into their MLR calculations than they would under the requirements for health benefit plans; and c.) prevent carriers from mischaracterizing certain administrative expenses as QIAs (thereby artificially inflating their MLRs). With respect to the last point, a QIA must not overlap with any administrative expense component listed under Section 2(b)(i)-(x). For example, any expense that pays for an item or commercial bearing the logo of the insurer cannot be considered an expense for a QIA, because it is a form of marketing expense, which is well-defined as an administrative expense.

We, therefore, propose the following requirements and restrictions for purposes of a regulatory definition for QIAs:

Quality Improvement Activity (QIA):

- QIAs must:
  - 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.

Lastly, to the extent that QIAs factor into the calculation of MLRs, they must be based on what each carrier *actually spends* on QIAs, and not merely a presumptive amount. See City of Columbus v. Cochran, 523 F. Supp. 3d 731, 768 (D. Md. 2021) (holding that, for purposes ACA's MLR requirement, insurers were required "to report the amount *actually spent* [on QIAs] and not a pre-determined fixed amount reflecting an average spent by insurers in years past") (emphasis in original).

SECTION 2(c):

1) **Is it clear that dental carriers will submit rate filings, including group product base rates and group rating factors, for the Commissioner's review and that these filings will be submitted using the Division of Insurance's standard processes on the System for Electronic Rate and Form Filing (SERFF) and will use all checklist materials and pay filing fees as identified in the SERFF system?**

   Yes, it is clear.

2) **Should there be separate filings for different markets? For example, should there be separate filings for products offered to individuals, small groups, medium sized 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 filing s for products with different network sizes, different benefit designs or different provider reimbursement (e.g. capitation and fee-for-service)?**

Yes, each market, group size, product design, network size, and provider reimbursement design provides a different value-proposition for patient-members. Given that Section 2(c) of the statute requires the commissioner to "disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable in relation to the benefits charged" and to disapprove any changes that are "not actuarially sound," the only way to fulfill these obligations is for each type to be broken out into separate filings.

3) **How are base rates to be calculated?**

See the answer to Question 4 below.

4) **How should the Division define "group rating factors"? Are certain factors to be banned (e.g., based on religion, culture) or limited? Are any rating factors permitted based on the past or predicted dental needs of any individual or group? Are rating factors permitted based on participation of the members of a group or based on the size of a group? Are rating factors permitted that may create different rates for individual and groups of one?**

The Division can use the 211 CMR 66.03 definition of "Rating Adjustment Factor" as a basis for the definition of "group rating factors," which specifies: "A factor permitted by state law … that is applied to a Base Premium Rate to derive the premium that is charged to a particular individual or employer." Like 211 CMR 66.07, the Division should limit permitted factors to a set list, where all other factors that are not listed are prohibited. This prevents the need to exhaustively list any other conceivable factor that should be prohibited.

The committee believes that group size and geographic location are actuarially sound bases for Rating Adjustment Factors. For group size, a "group of one" should have the equivalent rate to the individual rate. Therefore, any group size-based Rating Adjustment Factor should set the individual plan rate to the multiplier of 1.0, with rate adjustment factors being a multiplier of less than one for larger group sizes. For geographic location, the rate adjustment factor may be larger or smaller than 1.0, as determined by the Commissioner.

With respect to the factors that should be excluded (i.e., prohibited), the Division should exclude any factors that would constitute a traditional protected class under various anti-discrimination laws, including but not limited to race, color, religious creed, national origin, sex,

gender identity, sexual orientation, pregnancy, ancestry, status as a veteran, or genetic information.[1] Adjusting rates based on these categories would be discriminatory.

The Committee believes that age should also be excluded as a group rating factor.[2] Although age is currently included as a permissible rating adjustment factor under 211 CMR 66.07, it bears noting that this is an area where dental services deviate from other medical services. As explained by the American Academy of Actuaries in one of its publications: "The claim cost rates of most dental plans do not vary significantly by age in our experience. … [P]reventive care and basic restorations generally decrease in cost by age while major types of restorations increase with age. The typical dental plan … often balances out costs by service so that there is little difference in total costs by age." Thus, variable rates by age are not actuarially sound.

Additionally, past or predicted dental needs should not be included as a permissible adjustment factor. As the Division is no doubt aware, the Affordable Care Act does not permit health status as a factor to adjust ratings. See 45 C.F.R. § 147.102 (listing factors by which ratings may be adjusted); 78 Fed. Reg. 13432 (Feb. 27, 2013) ("The Affordable Care Act's … provision on fair insurance premiums will prevent issuers from charging a higher premium to individuals based on health status."). Likewise, no such factor is permitted under 211 CMR 66.07 for adjusting the rates of health benefit plans.

To extend this prohibition to the dental realm (i.e., to exclude any rate adjustment factors based on dental needs, dental history, dental status, etc.) would align with the overall purpose of Chapter 176X. The Supreme Judicial Court acknowledged that the purpose of the initiative petition which would ultimately become Chapter 176X is to "create an integrated regulatory scheme that would comprehensively address dental insurance rates that are excessive, inadequate, or unreasonable in light of the benefits afforded to policyholders…." Clark v. Att'y Gen., 489 Mass. 840, 845 (2022) (quotation marks omitted).

In light of that purpose, Chapter 176X extends various restrictions on dental insurance rates—including but not limited to the MLR requirements—from the health sphere to the dental sphere. Up until now, stand-alone dental plans were deliberately exempt from these requirements under the ACA and state law. Thus, the people of Massachusetts (by an overwhelming margin) sought to fill this gap, and rejected the notion that dental insurance should receive special treatment.

As such, the Division should bar dental status, or past/future dental needs, from being incorporated as rate adjustment factors. Doing so would comply with the clear intent of Chapter 176X, as it would treat dental benefit plans like health benefit plans with respect to rate adjustment factors. Indeed, it should be noted that Section 2(c) requires the Commissioner to

[1] Under Title I of the federal Genetic Information Nondiscrimination Act ("GINA"), carriers are prohibited from adjusting a group or individual's premium based on genetic information about an individual in the group.

[2] Although the Committee strongly believes that age should be excluded altogether, to the extent that the Division ultimately age as a group rating factor, it should limit the range of permissible rates to a more restrictive band than what is currently allowed in the non-dental context.

disapprove rating factors that are "discriminatory" and to promulgate regulations concerning this requirement. Agencies in other jurisdictions have interpreted similar language to bar the use of health status for rate adjustments. See, e.g., N.J. Admin. Code § 11:21-9.5(f)(3) ("Rates will be considered unfairly discriminatory if they are based on a health status-related factor of the group or any individual eligible for coverage in the group."). As such, the Commissioner may properly interpret "discriminatory" here to mean any rate adjustment that incorporates dental status.

Lastly, it should be noted that although Section 2(c) specifies "group" product base rates and "group" rating factors, the Division should properly interpret Section 2(c) to include base rates and rating factors for individuals. This is so because Section 2(c) explicitly applies to "carriers offering dental benefit plans," without further limiting to group plans. In turn, the definition of "dental benefit plans" includes both "stand-alone individual" and "group dental" plans. Thus, in the case where a carrier only offers stand-alone individual plans, they would nonetheless be obligated to adhere to the requirements of Section 2(c). However, it would be impossible for such a carrier to file their "group" rates if they only offer plans to individuals. Therefore, to bring harmony to the act as a whole, Section 2(c) must be interpreted to apply both to group and individual plans.

To further this point, Section 2(d) explicitly notes when the Commissioner must presumptively disapprove a carrier's base rate change for both groups and individuals as "excessive." This reference to disproval of "excessive" rates is a reference to the language in Section 2(c) requiring the Commissioner to disapprove rates that are "excessive, inadequate, or unreasonable…" Therefore, individual plans are also intended to be subject to Section 2(c).

5) **If the commissioner ever disapproves base rates, what are the appropriate criteria to determine whether the group-based rates are excessive, inadequate, or unreasonable in relation to the benefits charged? If the commissioner ever disapproves group rating factors, what are the appropriate criteria to use to determine whether the group rating factors are discriminatory or not actuarially sound?**

The Division should interpret these terms similarly to how they are used in M.G.L. c. 176J, § 6(c). It should be noted that the regulations under Chapter 176J do not spell out these terms in any great detail. This may be prudent, as these terms are firmly established in the insurance realm, with guidance provided by such organizations as NAIC, and to define them with too much particularity may inadvertently curb the Commissioner's discretionary authority. Nonetheless, to the extent that the Division believes it is necessary to provide further guidance on these terms (in addition to the three presumptive disapproval scenarios articulated by the law), the Division may wish to consider reviewing some of the more general language it has used for "inadequate" "excessive" and "unfairly discriminatory" rates, as those terms are used in the regulation of motor vehicle insurance under 211 CMR 79.04.

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

As there are no such exceptions to the July deadline articulated in the regulations for Chapter 176J, there likewise should not be any in the regulations for Chapter 176X. The Division should be strict about this deadline. Any filing past the July 1 deadline should only be allowed to the same extent and under the same circumstances as under Chapter 176J (if at all).

7) **Are the base rates submitted on July 1 in effect for each month in the following year? Are carriers allowed to vary rates by month?**

Yes, the base rates are in effect from January through December for the following year, hence the reference to "each year." Carriers should not be allowed to vary rates by month.

Once again, thank you for providing this opportunity for the Committee to comment on these important topics. We look forward to continue to work with the Division 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

Matthew Perry
Rosen & Goyal, P.C.
204 Andover Street, Suite 402
Andover, MA 01810
(978) 474-0100
mperry@rosengoyal.com

c.c. Dr. Mouhab Rizkallah DDS MSD CAGS
Chair of the Committee on Dental Insurance Quality

From: Rupp, Peggy K HHHH
To: Beagan, Kevin (DOI); Butler, Rebecca (DOI)
Subject: M.G.L. c. 176X,
Date: Tuesday, February 14, 2023 9:22:59 AM
Attachments: image001.png
image002.png

CAUTION: This email originated from a sender outside of the Commonwealth of Massachusetts mail system. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Hello Kevin and Rebecca,
I had a question about the new Dental Rate filing and reporting and since we will be continuing to discuss this on Wednesday I thought I would send my question today.

According to **ALM GL ch. 176X, § 4 –** Self funded plans are not in scope:

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.

However in the reporting section of the law there are requests to include self-funded information. I just want to confirm that self-funded plans are in scope specifically for the annual reporting requirements only.

Also I just want to confirm my understanding of the filing requirements and the reporting requirements. I read the requirements for rate filings to apply only to group dental plans. But the annual reporting requirements apply to both individual and group dental plans. Is that correct?

Thank you.

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

MASSACHUSETTS DENTAL SOCIETY
presenting YANKEE since 1976

Two Willow Street
Southborough, MA 01745-1027
800.342.8747 • Fax: 508.480.0002
massdental.org

February 17, 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 #2 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, it is the hope and goal of MDS to help establish a regulatory framework in the service of delivering the highest possible quality of dental care to state residents.

Regarding the information session held on February 1, 2023, the Massachusetts Dental Society would like to emphasize a key area of importance. We would like to note that our participation in this process is intended to help ensure that the regulations promulgated most closely resemble the spirit of the ballot question, the legislation that was enacted, and how Massachusetts voters would have understood and will be best served by its implementation.

We would like to start by drawing attention to the distinct differences between a proposed Dental Loss Ratio and the Medical Loss Ratios that are currently in effect for health insurers in Massachusetts and nationwide. While medical insurance plans no longer have annual or lifetime limits, dental insurance plans carry annual maximums. According to a 2019 white paper from the Milliman actuarial accounting firm, "Compared with medical lines of business, dental products typically have more predictable claim patterns, lower overall claim dollar amounts, and much lower risks and severities of catastrophic claims."[1] This predictability offers insurers greater control over their Dental Loss Ratios over time and should allow them to plan accordingly to comply with any new regulations.

[1] Is Your Dental Rating Manual State https://www.milliman.com/-/media/milliman/importedfiles/ektron/is_your_dental_rating_manual_stale.ashx accessed 2/5/2023

For Massachusetts dental providers the primary focus in this process is to ensure patients are getting reasonable value in their insurance products. Insofar as the implementation of this question, that insurers are to be held to standards that uphold the spirit and requirements of the Dental MLR Act and do not allow for the favoring of any one subset, or group, of providers in order to satisfy the requirements, while shaping the market to their desires.

The MDS is particularly concerned about insurers wanting to include subsidies or contributions for equipment or facilities as care, in a manner not contemplated by the Act's clear requirement that the dental MLR numerator be attributable to patient care much more directly. We are concerned that allowing these subsidies to count toward the numerator and not as administrative costs would permit an insurer to reward and enrich certain practices, in particular practices that may be affiliated in some way with the insurer itself. We want to underscore our desire to see regulations that assure that premiums are appropriately directed toward the care of subscribers no matter where those services are rendered. If, ultimately, such caveats are to be included in a Dental Loss Ratio they should be carefully calibrated or otherwise capped, if necessary.

We have previously discussed the distinctions between MLR and DLR and would like to consider the question of inclusion of Quality Improvement Activities (QIA) as part of that calculation. A strict definition of Medical Loss Ratio should be (Paid Claims)/(All Premium) for a given year, and we believe there are valid reasons for including a QIA caveat in the DLR calculation-or, alternatively, developing a QIA standard with much more input from key stakeholders and research experts, especially dental providers and consumers. These considerations are listed below:

1) While Health Insurers are deeply incentivized to partner with providers to minimize morbidity and re-admission and have established QIA structures to these ends, similar incentives do not necessarily translate in the dental insurance market; instead, insurers may be incentivized to maximize their portion identified as QIA to boost the "Paid Claims" portion of the DLR calculation. We can therefore expect dental insurers to adopt increasingly restrictive rules around utilization, such as frequency limitations on certain services, that are not necessarily motivated by actual outcomes.
2) While in medical insurance the standards for QIA have been developed over the years since the Affordable Care Act was enacted over a decade ago, there are not yet fully developed standards for dentistry. In the absence of such standards, the insurance industry should not be the lone stakeholder to develop these standards. In the absence of standards developed specifically for dentistry, we suggest a five percent ceiling on QIA spending should be established as a starting point, coupled with further evaluation of such QIA activities and submitted percentages going forward. A ceiling is appropriate based on federal data about MLR for major medical plans, where the percentage hovered around one percent in the years following the enactment of the Affordable Care Act.[2]

[2] https://www.gao.gov/assets/gao-14-580.pdf (Page 15, Table 2)

3) While QIAs in medical insurance must be tied to objectively measured health outcomes grounded in evidence-based medicine and best practices, it is worth noting that health insurance research and spending far outpaces that for dentistry. It is therefore difficult – but important - to establish what constitutes evidence-based outcomes for dentistry in the consideration of legitimate QIAs.
4) In the event that QIAs are included in the DLR calculation, we recommend that these be clearly delineated, such that insurers may not use such rules in order to favor or reward certain groups of providers or themselves.
5) We would strongly encourage DOI to use the standards, metrics, and parameters established by the Dental Quality Alliance for quality metrics and quality improvement initiatives. The DQA has engaged with a broad set of stakeholders, including the dental community and dental insurance corporations, to help devise widely accepted standards that could serve as a basis for any similar standards to be established by DOI in connection with the Act. [3]

While we appreciate including QIAs based on the MLR standard established by the ACA, we think it is important to appreciate the distinct differences between the medical and dental markets. Additionally, we would suggest that the DOI obtain full and robust input from diverse stakeholders on the specifics as to what qualifies as a ***dental*** QIA. We would like to ensure that insurers are truly engaged in quality improvement activities that directly benefit dental patients and are not using the category to hide costs that by rights should be viewed not as attributable to dental care expense, but to administrative costs. We believe DOI needs to carefully evaluate, based on further stakeholder input and guidance from dental provider experts, what rightfully constitutes appropriate dental quality improvement activities (and incentives).

Section 2. (a)

Question 1) Whether Out-of-State issuers should be subject to DLR rules.

The first question is whether "certificates of coverage given to Massachusetts residents through an employer plan, group trust or group association that is located in another state or jurisdiction" should be subject to the DLR rules.

It is our opinion that every state resident should have the benefits and protections provided by the passage of Question 2. While there may be circumstances where this is impractical to implement (e.g. a CA resident on a parents CA based plan attending university in MA), we believe that in circumstances where there are plans being offered to MA residents through companies headquartered in other states (e.g. a resident who works in Boston office of Seattle based company and carries a WA based dental plan) should be subject to the rules established in the wake of the passage of Question 2. Additionally, to offer and deliver insurance policies in Massachusetts, these insurance companies must have their products

[3] https://www.ada.org/resources/research/dental-quality-alliance/dqa-improvement-initiatives.

approved by the DOI, no matter where the insurance companies are domiciled. Further, other Massachusetts laws, enacted prior to the enactment of Question 2, apply to insurance company products regardless of where the company offering the products is domiciled.

Question 2) On distinctions between Group Products

Where distinct products exist, each product should at least be subject to a simple calculation of the DLR as we have previously proposed defining it: Incurred Claims divided by the Premium (earned and unearned) over the calendar year. How the DOI delineates the requirements for filing expenses we leave to the discretion of the DOI, but request that information be made available to allow for the assurance of compliance with the statute.

Section 2. (b)

Question 1) We believe reporting should happen before rate filing. It stands to reason that for rates filed for the upcoming year the DOI should have the previous year's reporting in order to effectively evaluate current filings.

Question 3) Yes

Question 4) Yes

Section 2. (c)

Question 2) We request that the DOI require filings consistent with distinct product offerings and designs. Reporting for Individual, Small Group and Large Group offerings at a minimum should be adopted.

Question 4) We would suggest that the only relevant rating criteria are group size and geography.

Revisiting a proposed definition of DLR (updated):

Definitions:

Incurred Claims: Incurred claims is any reimbursement for clinical services paid to or received by providers, for any Clinical Service affiliated with a filed CDT code or any service provided by a licensed dental provider (DMD, DDS, RDH, CDA, DA) that is reimbursed via a 3rd party (between provider and patient). Incurred claims shall include all claims made in a calendar DLR year, and not include overpayment recoveries (claw backs) made for the DLR year. Overpayment recovery amounts should be removed from the incurred claims calculation.

Premium Revenue: Earned Premium plus Unearned Premium over given calendar year.

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

Unearned Premium: Unearned premium is all monies agreed to be paid by policyholders or subscribers as a condition of receiving coverage from the issuer including any fees or other contributions associated with the dental plan that are as yet unpaid.

Utilizing these definitions, we submit the following definition of **Dental Loss Ratio**

§ 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.

(C) ***Denominator:*** The Denominator of an issuer's DLR of a DLR reporting year must be the insurer's Premium revenue.

Subsequently, the DOI should ensure that the DLR comports with the administrative expense reporting supplied by carriers.

In closing, we would like to note that for the Massachusetts Dental Society members, it is of paramount importance that all the regulations adopted in the implementation of Question 2 protect patients, ensure benefits are directed toward care, and ensure insurers are hewing closely to the patient protection mission of Question 2. 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 800.342.874 if you have any questions about these comments.

Respectfully submitted on behalf of the Massachusetts Dental Society,

_____

By: Kevin Monteiro
Title: Executive Director

BLISH & CAVANAGH LLP
COUNSELLORS AT LAW

Joseph V. Cavanagh Jr.
William R. Landry
Edmund L. Alves, Jr.
Scott T. Spear
Mary Cavanagh Dunn
Joseph V. Cavanagh, III
Christopher J. O'Connor
Robert J. Cavanagh, Jr.
Matthew J. Landry

Steven I. Rosenbaum
Of Counsel

John H. Blish
(1986-2007)

Commerce Center
30 Exchange Terrace
Providence, RI 02903-1765

Tel (401) 831-8900
Fax (401) 751-7542
www.blishcavlaw.com

March 14, 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 Section 2 (Discussed At Session #2);
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 (Second) Informative Session, dealing with section 2 of c. 176X, we respectfully submit the following comments:

As to Section 2(a); Q #1, 2

• We do believe it is clear that the Commissioner has the authority to review and approve insured dental benefit policies. However, we respectfully submit that benefit plans "being proposed to individuals and groups" include plans and certificates already on file and approved by the Commissioner and should not be required to be re-filed. That requirement should be limited to *new* plans.

• It would not be feasible for dental insurers to be able to submit rates and policies incorporating a medical loss ratio for plans "to be offered on and after January 1, 2024". The Commissioner is not required to adopt regulations under the new statute until October, and rate

proposals to groups for January 1 are developed and provided to groups as much as six months ahead of the following calendar year, well ahead of when the regulatory calculation methodology for the dental loss ratio is likely to be available.

• It seems clear that M.G.L. c. 176X applies only to insured group dental plans that are issued and delivered in Massachusetts. Certificates of coverage issued to individuals in Massachusetts that are effectively **individual** coverage (whether issued by an employer plan, group trust or association located in another state) **should** be subject to c. 176X. The "issued and delivered" principle applies to group insurance.

• We do believe it is clear that dental carriers may offer insured dental benefit policies that provide benefits through a network of dental providers and many offer products with different provider networks, including those that may be a subset of an existing dental provider network.

• With respect to whether the Division should issue guidance so that dental carriers prominently identify a product's network and provide any explanation when it may offer different provider networks among its groups of dental products, we do not believe this to be a significant issue. Altus presently provides such prominent differentiation.

• Any eligibility criteria considered by the Division should simply track the existing statutory provisions applicable to dental insurance, including but not limited to M.G.L. c. 176O and the exemption from most managed care regulation applicable to "limited scope vision or dental benefits offered separately" set forth in M.G.L.c. 176O Sec. 1 and M.G.L.c. 176J, Sec. 1.

It does not appear that new c. 176X requires substantive changes in the area of provider network contracting.

As to Section 2(b); Q #1, 2, 3, 4

• Yes, it is clear that the Commissioner of Insurance has 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.

However, it bears noting that *the fact that the expenses listed in Section 2(b) are properly required to be* ***reported*** does not mean that they are all to be included in the actual ***calculation*** of the dental loss ratio. Section 2(b) specifically provides for ***the Commissioner*** to ultimately determine which of these categories of expenses will factor into the actual ***calculation*** of the dental loss ratio. This includes all the categories of expense set forth in Section 2(b) (i) through (x). This includes, but is not limited to, external broker/consultant fees that are merely passed through the carrier as a courtesy to the customer, as well as premium taxes.

Altus has already discussed in detail in its written comments on the Session 1 issues (submitted on January 30, 2023) the reasons why it would be fundamentally unfair and infeasible for expenses – like external customer broker commission pass-throughs – to be counted as administrative expenses. They are not expenses of the carrier at all. Those comments similarly discussed how extraordinary and unfair it would be to include federal and state taxes as administrative expenses as part of a high-end dental loss ratio like the one set forth in M.G.L. c. 176X. The high end-medical loss ratios – including the one in the Affordable Care Act that was developed by the NAIC – specifically excludes federal and state taxes from administrative expenses. This is how Altus and other dental plans are required to file their loss ratios with the Division for products on the Mass Connector exchange.

That discussion detailed how the inclusion of external pass-through brokers commissions and premium taxes or "administrative expenses" – which they are not – would render it impossible for dental carriers to retain sufficient post-expense – revenue with which to run the business.

• The expense information set forth above should be reported in a manner that distinguishes insured business from self-insured business, as the latter is not subject to M.G.L. c. 176X.

The required expense filings should be made annually following the prior rating year's experience, and should be in the nature of a "trend" factor in the rate filing. Most other loss ratio requirements – including the ACA's have been phased in as part of a sequence that includes a three year ramp-up period of rating years.

• With respect to the overlapping structure that Section 2(a) employs with respect to certain administrative expenses, it seems reasonable for the expenses set forth in the "first" items (i) – (iii), the more "definitional" items, to be considered as part of the "second" items (i) – (x) for loss ratio ***reporting*** purposes. As set forth above, the determination of which items of expense should be included in the loss ratio ***calculation*** is an entirely separate matter.

As to Section 2(c); Q #1 - 7

• It is clear that dental carriers will submit rate filings, including group product base rates and group rating factors, for the Commissioner's review, and that this will be done using the Division of Insurance's standard processes, utilizing SERFF. As set forth above, it is not feasible for rates to be submitted for plans "to be offered on and after January 1, 2024" in view of the current timetable for regulations implementing c. 176X.

• With respect to whether there should be separate rate filings for different markets and product and network designs, the Commissioner appears to have considerable discretion in this regard. Carriers should not be required to modify product filings already on file except with respect to the dental loss ratio factor which, under M.G.L. c. 176X § 2(d) is not specific to any

particular market or plan or product or network, but is required to be based on "the aggregate medical loss ratio for all plans offered."

• The "group rating factors" to be utilized should track those generally applicable in the industry, including experience rating elements for large groups, and community rating for individuals in accordance with 211 CMR 66.07. Both 211 CMR 66.07 and the ACA (45 CFR § 147.102) specifically provide for the inclusion of an age and area, with the former more specifically also including benefit level rating adjustment factors.

In all events similarly situated categories of covered persons must be treated consistently.

• Carriers should be allowed to make rate filings other than at the noted July 1 period. This occurs routinely, particularly where new product offerings are introduced. Where rates contemplated by M.G.L. c. 176X are filed by July 1 for plans offered the following calendar year, yes, they should remain in effect for each month the following year.

• Importantly, it should be noted that Altus and other dental insurers often provide multi-year rate guarantees. For example, municipal groups in Massachusetts (which account for roughly one half of Altus' business) frequently rely on such rate guarantees – up to 4-5 years out – for fiscal predictability and stability. They are crucial for carriers for the same reasons. Nothing in the implementation of c. 176X should interfere with or disrupt those existing contractual arrangements.

Thank you for this opportunity for Altus to again 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