Chapter 287 of the Acts of 2022

Information Session #2 on Wednesday, February 1 at 1PM – Filing

Section of 1 of Chapter 287 creates Chapter 176X. Section 2 describes the process to file and review rate materials. Session 2 will concentrate on subsections (a), (b) and (c).

Section 2.(a)

"Notwithstanding any general or special law to the contrary, the commissioner may approve dental benefit policies submitted to the division of insurance for the purpose of being provided to individuals and groups. These dental benefit policies shall be subject to this chapter and may include networks that differ from those of a dental plan's overall network. The commissioner shall adopt regulations regarding eligibility criteria."

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 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?

2) 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? 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?

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

Section 2.(b)

“Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering dental benefit plans to submit information as required by the commissioner, which shall include the current and projected medical loss ratio for plans the components of projected administrative expenses and financial information, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including but limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants; and

(iii) claims operations expenses, including, but limited to, adjudication, appeals, settlements and expenses associated with paying claims.

Unless otherwise determined by the commissioner, the following items shall be deemed to be an administrative cost expenditure for the purposes of calculating and reporting the medical loss ratio:

(i) financial administration expenses;
(ii) marketing and sales expenses;
(iii) distribution expenses;
(iv) claims operations expenses;
(v) medical administration expenses, such as disease management, care management, utilization review and medical management activities;
(vi) network operations expenses;
(vii) charitable expenses;
(viii) board, bureau or association fees;
(ix) state and federal tax expenses, including assessments; and
(x) payroll expense.

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? Are there any other filings that should include these expenses?

2) During the session held on February 18, 2023, many of the items identified in this section were identified as ones that may need to be defined in order to obtain consistently reported information from each of the reporting dental carriers.

3) 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?

4) 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? 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?

Section 2.(c)

"Notwithstanding any general or special law to the contrary, carriers offering dental benefit plans, including carriers licensed under chapters 175, 176B, 176E, 176G or 176I, shall file group product base rates and changes to group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate, or unreasonable, in relation to the benefits charged. The commissioner shall disapprove any change to group rating factors that is discriminatory or not actuarially sound. The commissioner shall adopt regulations to carry out this section."

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? What about individuals?

2) Should there be separate flings 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)?

3) How are base rates to be calculated?

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?

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?

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

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?