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March 1, 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 #3 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. We have prepared the following responses to the questions posed by DOI and discussed at Session 3, held on February 15th, 2023, on the process to file and review of rate materials under the Act.

I. Introduction

At the outset, the MDS would like to note that the Act is prescriptive with respect to the requirements for a carrier to refund excess premium to covered individuals if the "annual aggregate medical loss ratio … is less than the applicable percentage set forth in subsection (e)." The Act further provides that DOI may only issue a "waiver or adjustment of this requirement" in the event that it is determined that issuing refunds would result in "financial impairment" for the carrier. The Act clearly and unequivocally spells out that insurers not meeting the dental MLR of 83% must conduct a refund to consumers, stating: "The total of all refunds issued shall equal the amount of a carrier's earned premium that exceeds that amount necessary to achieve a medical loss ratio of the applicable percentage set forth in subsection (e) [i.e., 83%]."

II. Comments on Section 2d; Consumer price index (CPI) for dental services

Given this clear directive, the DOI should hew closely to objective measures for the criteria it uses for determining whether a carrier has fallen short of meeting the dental MLR

and therefore owes refunds to consumers under the Act. The MDS recommends that the national dental CPI be utilized, as to our knowledge, there are not yet regional or urban dental CPI standards yet established. We would further recommend that the DOI ultimately consider following what has been done on the medical side under the federal Patient Protection and Affordable Care Act of 2010 (ACA). More information should be collected by DOI to evaluate how CPI is established under the ACA. We would then recommend the DOI solicit and obtain information, with input from multiple, diverse dental stakeholders and experts, on regional differences in order to establish a similar corollary in the dental MLR arena, for CPI. Since we are not aware that one currently exists, we recommend that DOI use the national dental CPI for purposes of initial implementation, as articulated by the U.S. Bureau of Labor Statistics. See https://www.bls.gov/news.release/cpi.t02.htm.

III. Comments on Section 2e; Review Standards

1) The MDS believes that carriers should be required to submit information in a manner that includes sufficient detail about how total administrative expenses are projected to increase within the filing, so that DOI can compare it with the presumptive disapproval standard. As per the response to question I above (to question 2d), the MDS recommends that the national dental CPI be used consistent with U.S. Bureau of Labor Statistics for determining an appropriate basis for rates.

2) The MDS also believes that all parties-carriers, providers, and consumers-would be best served if the DOI would calculate and announce specific details, changes, and comparisons relating to the dental price index that is selected in advance. That way, carriers can be put on notice of the standards and strive to meet them prospectively, which will reduce the need for retrospective adjustments and refunds and promote greater certainty and stability in the market. We would propose that the period of comparison run annually, based on the calendar year.

3) The MDS agrees with the statement of Mr. Beagan and others at the Session three meeting that the items listed in section 2e for presumptive disapproval of rates as excessive are requirements for presumptive disapproval, but that the Act does not limit the DOI to that list. The overarching concern of the MDS is to ensure that DOI will presumptively disapprove a carrier's base rate change if it increases violate any of the statutory factors established by the Act: increases by more than the most recent "calendar year's percentage increase in the dental services CPI, or ….surplus" that "exceeds 1.9 per cent or if the carrier's aggregate MLR for all of its plans is less than 83%," or is otherwise unreasonable or excessive. The MDS would encourage the DOI to develop standards around what constitutes a rate increase that is presumptively excessive, while retaining sufficiently flexible regulatory language so as to retain full authority to disapprove excessive rate increases.

4) The MDS strongly encourages the DOI to include guidance on what is considered patient care expenses versus what is considered administrative expenses. The determination of what counts toward the 83% will be critical to ensuring that the implementation of the Act is consistent with the intent of the legislation. The ACA should be

used as a road map in terms of identifying carrier line-item expenses, and how they are classified, using the guidance from the medical arena in the implementation of the new dental MLR. In terms of how carriers should submit information-we believe that in order to present sufficient detail, a refund calculation sheet should be included. It is of paramount importance that the DOI adopt and maintain full transparency as to the components of calculating the MLR; in other words, what constitutes the care costs versus the administrative costs used to determine the MLR and adherence to the 83% standard. Without sufficient detail in either the regulations or the carrier submissions, the requirements of the Act could be seriously undermined to the detriment of dental patients.

5) As we noted in our most recent submission to the Second Session questions from DOI, we feel that it will be very important to specifically determine whether items such as quality improvement initiatives should count toward the 83%, and if so, what percentage-and most fundamentally, - what activities, exactly. We also clarified that we feel national standards (cited in our previous submission) should be followed, where they exist, for QIAs and other items that the DOI may determine to be permissible for carriers to include and attribute to the 83% MLR requirement, and that more diverse stakeholder engagement will be needed for items where there is an absence of applicable dental standards or criteria. In the absence of objective criteria to demonstrate improvement for outlays on activities that are designated as a QIA, the DOI should consider such activities to be administrative as opposed to a QIA attributable to patient care, for the purposes of the calculation of the dental loss ratio. We would also note that there has been recent focus on inappropriate manipulation of QIA reporting and activities by CMS in the medical arena and would urge the DOI to adopt regulations that preclude such manipulation by carriers in the dental arena. https://chirblog.org/questionable-quality-improvement-expenses-drive-proposed-changes-medical-loss-ratio-reporting/. Overall, unless and until evidence based QIAs demonstrating improved patient outcomes are developed with significant input from and by the dental provider community, the MDS would encourage the DOI not to permit QIAs to be included as attributable to the 83% MLR.

Additionally, the MDS recommends that such activities cannot be utilized to favor a subset of providers based on non-clinical factors and should be able to demonstrate improved outcomes for clearly defined patient groups (e.g., patients with periodontitis, or patients with diabetes). Overall, the MDS would advocate for the DOI to consider a path for the development of objective, evidence based quality metrics, rather than (or at least contemporaneously with) standards for QIAs. The MDS would note that it is very important that any quality metrics to be established should be by a government entity and/or independent professional organization without an interest in the market beyond improving patient outcomes, to avoid inappropriate bias being incorporated into payment and quality measures.

6) With respect to whether to follow existing DOI regulatory requirements for some similar types of filings for the Act, our thoughts are as follows. Generally, the MDS supports the DOI referring to and potentially adopting reporting structures and requirements that already exist in its regulatory rubric, where applicable (for example, merged market /different contribution to surplus standards), with an important caveat: The Act is new, and the DOI would need to

carefully evaluate and consider the appropriateness and potential unintended consequences of adopting identical requirements for insurers in the dental market.

7) The MDS believes that if the Division reviews a filing and believes that the filing does not satisfy a presumptive disapproval standard, the carrier should be notified promptly, in written form. While the MDS supports giving the carrier a chance to amend, a short time frame should be afforded for doing so. The MDS believes the DOI should provide a very limited time-we agree with the comment that one day should be the limit- for rate calculations to be updated/amended before a hearing proceeding is initiated. The MDS also agrees that there may need to be a transition period for the format and content of reporting filings given the newness of the Act but would caution against it being too long or fluid: the need for the permanent and clearly delineated filing and rate review process is critical to implementing the Act effectively, in a timely fashion, as contemplated by the Act's requirements.

8) The MDS believes that there should be a standard refund calculation worksheet that is filed separately from the rate filing that presents information used to calculate potential refunds. We believe that the refund calculation sheet should be a different one for different markets, and agree with the observation that this is standard in the vast majority of states that have merged markets: namely, that there are separate calculation sheets required, not aggregate refund calculation sheets. The Division of Insurance should have full authority to disapprove any plan that does not meet the statutory timelines or does not adequately distribute/credit refunds to members, to be consistent with the Act requirements and intent. We believe that carriers should be penalized (e.g., interest penalties) for any refunds that are not properly transmitted to members within the statutory timelines for refunding premiums to members.

Overall, we are in favor of all refunds owed under the Act being returned promptly and transparently to consumers. Relatedly, we do not feel the Division should waive or adjust the level of refund; if the DOI feels there is some discretion needed to do so, it should be clearly spelled out and carefully circumscribed, both in terms of the circumstances that would allow it to exercise such discretion, and the range of amount.

If the DOI determines the refund amount to be truly de minimus, the DOI could consider permitting it to be rebated in the form of a discount on the next year's premium rather than returned. We believe that if this discretion is applied very narrowly it would be consistent with the spirit and language of the Act. If DOI decides to follow this approach, it will be important that any amount of rebate to consumers that would be applied to the following year premium be made very transparent.

Relatedly, we do not feel the Division should waive or adjust the level of refund; if the DOI feels there is some discretion needed to do so, it should be clearly spelled out and carefully circumscribed, both in terms of the circumstances that would allow it to exercise such discretion, and the range of amount. The MDS further believes that the standard for DOI to determine that "issuing refunds would result in financial impairment for the carrier"

pursuant to section (d) must be very clearly spelled out, narrowly tailored to true risk of insolvency cases and made transparent to all stakeholders, as it would otherwise undermine the clear language and intent of the Act to permit carriers to deny consumers rebates owed to them under the law. Again, overall, the MDS feels strongly that the consumer should receive the full amount of all refunds from carriers identified as due under the Act, consistent with both the letter and spirit of the legislation.

9) The MDS encourages the DOI to consider establishing clear rules regarding the way in which out of network providers and the payments to such providers should be permitted to count toward the 83%. One important concern is that when payments for out of network provider services are made directly to the patient, the dental provider who has provided the services may never be paid by the patient. We believe that when the dental provider does not receive the payment for the services provided to the patient, attributing such payments to patient care services-and to the carrier's 83% amount- is not consistent with the intent or language of the Act. The MDS encourages the DOI to establish a mechanism for tracking such collections so that payments attributable to the 83% are appropriately made to those incurring the costs for them: the dental service providers. .

IV. Comments on Section 2f; Effect of Disapproval

1) The MDS believes that there need to be restrictions on carriers' ability to market dental products when they are subject to a hearing. If they are permitted to market while subject to a hearing, they should be required to make clear that there is a hearing pending, and a summary of the issue. Overall, MDS supports the greatest level of rate transparency with consumers, so that they are not unpleasantly surprised, curtail or avoid needed dental treatment, or fail to pay their share of the cost to their providers because payment from the carrier is in question. The MDS would encourage the DOI to prevent any retrospective recoupments or clawbacks from consumers due to subsequent rate disapprovals by DOI, and to impose appropriate restrictions on carriers to ensure that does not occur. Otherwise, consumers may likely avoid treatment and may fail to pay providers their share due to hardship or fear that the premium they paid was not firmly established and may in fact cost them additional amounts down the road.

2) The MDS would like to call the DOI's attention to the issue of clawbacks and recoupments from dental providers by carriers and/or employers. Specifically, if the carrier recoups payments from a dental provider (e.g., as excessive or otherwise improper or incorrect), how will that be reflected in the MLR calculation for the year to which it is attributable? The DOI should also consider and establish clear rules regarding how such recoupments from dental providers should impact a carrier's MLR calculation for the upcoming year as well. The MDS would encourage the DOI to make clear that the recouped amount must be reallocated by the carrier on its rate calculation sheets and rate approval related submissions as not attributable to patient care (and therefore not part of the 83%.)

3) The MDS believes that consistent with the requirements of Section 2.(f)(i), the communication that goes to all employers and individuals covered under a group product that the proposed increase has been presumptively disapproved and is subject to a hearing should also go to individuals covered under an individual product when that product's rate increase has been presumptively disapproved-and to a group association where relevant. The information should be communicated to these categories of stakeholders promptly after a carrier has been notified, to ensure transparency and reduce surprises and the risk of reduction in seeking, obtaining, and ability to pay for appropriate dental care that emanates from such surprises.

V. Comments on Section 2g; Disapproval Notification; AG Involvement

1) The MDS supports the DOI including information in the presumptive (or regular) disapproval notification to the extent possible. The MDS also supports the DOI notifying individuals that a rate has been disapproved, with the goal of promoting rate transparency as well as more certainty for individuals. We believe that there should be some mechanism for providers to be advised of rate disapprovals for services they may already have rendered, so they are aware of the access, service delivery, and payment issues that may arise. The MDS believes the DOI should evaluate and select the most effective method or methods of transmitting such notifications and make clear to stakeholders what those methods will be.

2) The MDS agrees that for regular disapproval, it may be prudent for the DOI to use timeframes and processes established on the medical side in its regulations, taking into account any differences between the dental and medical markets, as well as any issues that those processes may raise that could be improved upon here.

3) The MDS believes that the DOI should adopt clear formal procedures for the public hearing, and provide formal notification in the noted cities. With respect to the role of the Attorney General (AG), the MDS believes regular reports by the DOI to the AG detailing the number and types of disapprovals and amount of rate changes would be important. Additionally, the MDS recommends that the DOI invite the AG to take an active role in investigating rate issues that are of a certain scope or concern. The AG could be invited to take part in certain hearings-or potentially all of the presumptive disapproval hearings as well. These government findings and activities should be regularly reported to the MDS and dental stakeholder community, as well. With respect to the discussion at the Session Three meeting and whether chapter 30A applies, we believe it is clear that it does, and the 30A process for a hearing must be adhered to.

VI. Conclusion

In closing, we would like to note that for the Massachusetts Dental Society members, it is of paramount importance that all the regulations adopted to implement the Act protect patients, ensure benefits are directed toward care, and ensure insurers are hewing closely 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,

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By: Kevin Monteiro
Title: Executive Director

ROSEN & GOYAL, P.C.

March 2, 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 15, 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. The Committee answers the questions posed by the Division on Sections 2(d) – 2(g) of M.G.L. c. 176X as follows:

SECTIONS 2(d) and 2(e):

Review standards

1) **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**

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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?

All information requested in Section 2(b), including the expenses delineated under (i) through (x), should be included as part of a carrier's projection of administrative expenses. In determining the amount of these projected expenses, carriers should identify the data sources used, such as historical data based on the carrier's experience (provided that the carrier has sufficient historical data), or other external sources. Carriers should also describe in detail what assumptions and bases they are using to arrive at their projected administrative expenses, such as assumptions about lapses and trends in coverage.

The change in pricing for dental services (U.S. city average, all urban consumers, not seasonally adjusted) is available through the U.S. Bureau of Labor Statistics' monthly releases of the consumer price index ("CPI").[1] As such, the Division need not calculate this data, but it may be useful to announce it to carriers when this information becomes available. There should not be any adjustments for the New England, Massachusetts, or Boston metropolitan areas because M.G.L. c. 176X does not call for regional adjustments (unlike M.G.L. c. 176J, § 6 which calls for the "New England" CPI), but rather explicitly calls for the U.S. city average. In any event, the price fluctuations that result from geographic location can be captured by the carrier as a rate adjustment factor.

Lastly, the most recent year's percentage increase should be on based a comparison of the CPI data for dental services in January of the current year to the CPI data for dental services in January of the prior year. As an example, for rates that will be effective on January 1, 2024, they should not increase by more than the percentage increase in the dental services CPI from January 1, 2022 until January 1, 2023. The Committee believes that using January as the point of comparison, rather than November as done for health benefit plans, would be most effective in capturing the "most recent" calendar year's percentage increase, while there may be information that is lost if November is used as the point of comparison.

2) **Within the rate filings, how should carriers submit information so that it present 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?**

Yes. The contribution-to-surplus standards and methodologies provided under 211 CMR 66.08 should be adopted by the Division for the dental insurance rate filings.

3) **Within the rate filings, how should carriers submit information so that it presents sufficient detail about the projected loss ratio for use in evaluating the filing in**

[1] A table for dental services (U.S. city average, all urban consumers, not seasonally adjusted) is available at the following URL on the BLS website: https://data.bls.gov/timeseries/CUUS0000SEMC02.

relation to the presumptive disapproval standard? Should the calculation follow a standard formula so that it is reported from one company to another? How much detail should be expected to be included in the derivation of this calculation? If there are separate rate filings for differing group size markets (e.g., individual, groups of 1-50, groups of 100), should the loss ratio be calculated for each market based on the experience and products offered in that market? What, if any, adjustments to claims or expenses should be permitted? In the federal MLR calculations for health products, there are adjustments for items such as quality improvement or fraud fighting; should the loss ratio calculation allow the same adjustments permitted under federal MLR rules and if not, how should it differ?

Carriers should submit as much detail for the projected loss ratio as they do for health benefit plans, including but not limited to the three-year historic MLR, and a standard formula should be utilized to prevent carrier manipulation and allow for MLR comparisons between carriers. Loss ratios should be calculated for each market based on the experience and products offered in that market, which will prevent carriers from masking MLR deficits in one market with the experience and products offered in another market.

With respect to allowances for quality improvement activities ("QIAs"), please refer back to the Committee's previous letter, which explains that they should not be included but, if they are, certain limitations must be put in place.

Lastly, carriers should not be permitted to increase the numerator of their MLR through any fraud fighting, because such activity is properly categorized as a type of medical administration expense (which is explicitly defined as an administrative cost expenditure in section 2(b) of Chapter 176X). Fraud fighting is accomplished through several medical administration activities, such as utilization review (which is, again, an administrative cost expenditure). Similarly, for health benefit plans, fraud detection and prevention (under 211 CMR 66.08(1)(j)) is classified as a medical administrative expense to be used in the denominator of the MLR calculation. Adding utilization control to the numerator would be a violation of both the spirit and the letter of the law.

4) **When calculating the projected loss ratio for purpose of the presumptive disapproval standard, should the calculation allow for rounding and if so, at what decimal level?**

The Division should adopt the federal standard under 45 C.F.R. § 158.221(a)(2) of rounding 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."

5) **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 carrier 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?

In keeping with the Division's practice with presumptive disapprovals for health benefit plans, the Division should first informally notify the carrier when a rate is presumptively disapproved, explain why the presumptive disapproval, and notify the carrier of a finite period (no more than a week) to cure any inadvertent error that may have occurred leading to the presumptive disapproval. This would avoid the scenario of unnecessarily scheduling a public hearing, and save both time and expense.

To the extent that the carrier does not submit an updated or amended rate calculation that cures the presumptive disapproval within the finite period specified, the Division should then issue a formal notice of presumptive disapproval. A notice of presumptive disapproval should include:

- the reason(s) for presumptive disapproval, including an explanation for how the rate was calculated to violate the administrative expense loading component, contribution to surplus, and/or MLR requirements of section 2(d);
- a citation to the specific portions of Chapter 176X and the regulations thereunder through which the rate was presumptively disapproved;
- a date/time/location for the public hearing, as well as any other information to access the hearing (such as, for example, Zoom details, to the extent it is held remotely);[2]
- a brief description of the purpose of and procedures available at the public hearing, including witness testimony, etc.;
- a **conspicuous statement** (e.g., in bold, underlined font) of the carrier's obligation to notify those covered under its plan of the hearing.

6) **Are carriers permitted to market dental products when they are subject to a hearing? If yes, what would carriers be required to say about the hearing? Are they only permitted to offer rates that are in place prior to the rate filing? If the hearing has not concluded prior to the rates become effective, are the rates required to remain at that level for the duration of the rating year or would carrier be permitted to adjust rates if a disapproval is overturned following a rate hearing conducted according to section 2(f) or (g).**

Carriers should not be allowed to market their rates while said rates are subject to a hearing (though that is not to say they could not market other aspects of their plans, such as their provider networks). The Committee is of the mind that marketing rates under such circumstances poses too substantial a risk that carriers may engage in unlawful and deceptive practices, in violation of the Commonwealth's consumer protection laws, that will mislead consumers about plan prices. See, e.g., 940 CMR 3.04 (attorney general regulation prohibiting deceptive pricing).

[2] To the extent that the public hearing has not yet been scheduled at the time the notice of presumptive disapproval has been issued, then a follow-up notice concerning this information once it has been scheduled should be sufficient.

Nonetheless, to the extent that the Division does ultimately allow advertising of rates while a public hearing is pending, safety measures should be put in place to make the situation as clear as possible to consumers. For example, any marketing should include the current rate, the fact that the rate is subject to a public hearing, and the possible effects on the rate depending on the outcome of the public hearing (including the possibility that the rates may increase). This information should be presented as conspicuously and as frequently as possible (e.g. in bold, large font).

Carriers should only be permitted to offer prior rates while the public hearing is pending. In the event that a disapproval is overturned, under no circumstances should the carriers be permitted to make retroactive adjustments. This is inequitable to the consumers, violates the spirit of the law (as it may trap consumers into inadvertently buying a plan they cannot afford), and is not something that can be reasonably remedied through clarity in advertising.

Refund Calculations

1) **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?**

There should be a standard refund calculation worksheet, like that under 211 CMR 66.08(8)(a), that is filed separately from the rate filing and presents information used to calculate potential refunds. The worksheet is important to verify that carriers are complying with the law's refund requirements and calculating the refunds correctly. The calculations should look at actual (as opposed to projected) premiums, claims and expenses for the prior calendar year, as Section 2(d) calls for refunds based on the "annual" medical loss ratio, without referencing to any projected amounts.

Calculations should not and more importantly cannot follow the federal standard of using a three-year average to determine the refund amount. The three-year average under federal law is explicitly laid out in a statutory requirement under 42 U.S.C. § 300gg-18(b)(1)(B)(ii). Conversely, there is no such statutory requirement under Chapter 176X. Again, Chapter 176X uses, as the basis for refunds, the "**annual**" medical loss ratio. It does not say "three-year average," or equivalent language. The plain meaning of "annual" is clear. Therefore, there is no authority to make refund calculations on a three-year average, or anything else other than the annual MLR.

Finally, Massachusetts should (like the majority of states do for their health MLRs) separate the rate filings by market and, in turn, require separate refund calculation worksheets for each market. As previously noted, requiring separate MLR filings will prevent carriers from masking MLR deficits in one market with the experience in another market. Likewise, requiring separate rebate filings will prevent carriers from attempting to mask when a rebate may be owed in a particular market.

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

Like under 211 CMR 66.08(8)(a), carriers should be required to submit a rebate calculation form by July 31 for the previous calendar year.

3) 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 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 for refunds (e.g., with interest penalties) for any refunds that are not properly transmitted to members within the statutory timelines for refunding premiums to members?

There should be an implementation plan, like that under 211 CMR 66.08(8)(b), that the carrier must file when a refund is warranted that documents how the carrier will notify all affected individuals and groups, and process the appropriate refunds. These plans should also specify the ways that carriers will follow up with impacted individuals/groups who are not reachable at the location that the carrier has on file. It is important to verify that the carriers are making all reasonable, meaningful efforts to notify all impacted individuals/groups, as otherwise carriers would be incentivized to provide as little notice as possible, in the hope that these individuals/groups would not claim the refunds to which the law entitles them.

To that end, the Division should be authorized to disprove any implementation plan that does not meet the appropriate statutory/regulatory timelines or that does not adequately distribute or credit refunds to members. Authority to disprove will better ensure that carriers comply with the rebate requirement, as would imposing interest as a penalty for failure to timely refund.

The Committee believes that, unlike 211 CMR 66.08(8)(d), there should be no waivers or adjustments for *de minimus* refunds. As the Division is aware, dental premiums cost substantially less, generally, than healthcare premiums. As a result, when refunds are triggered under Chapter 176X, they are likely to also be substantially less. Allowing *de minimus* waivers could therefore give the carriers a means of avoiding refunds in most or nearly all cases, violating both the spirit

and the letter of the law (as Section 2(d) authorizes waivers or adjustments "**only**" if it would result in financial impairment for the carrier, not where the refund would be *de minimus*).

Despite this, to the extent that the Division ultimately decides to allow for *de minmus* waivers or adjustments, two key provisions must be implemented: (1) as under 211 CMR 66.08(8)(d), the aggregate of any *de minimus* amount not refunded must instead be used to reduce overall premiums; and (2) the level for a *de minimus* amount of dental premium refunds must be substantially lower than the level for health premium refunds. In setting this lower threshold, the Division may wish to consider what percentage of the average health premium in Massachusetts constitutes a *de minimus* health premium refund, and then multiplying that percentage by the average dental premium in Massachusetts to arrive at the *de minimus* dental premium refund.

4) **What factors should the Division consider when deciding whether to waive or adjust the level of refund?**

The Division should be permitted to consider waiving or adjusting the refund **only** when, as articulated under 211 CMR 66.08(8), "the Commissioner determines that issuing such refunds would result in Financial Impairment," i.e. in a situation where "the Carrier is, or … could reasonably be expected to be, insolvent, or otherwise in an unsound financial condition such as to render its further transactions of business hazardous to the public or its policyholders or Members, or is compelled to compromise, or attempt to compromise, with its creditors or claimants on the grounds that it is financially unable to pay its claims." 211 CMR 66.03.

SECTION 2(f):

1) **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 individual's 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?**

Yes, where a proposed increase has been presumptively disapproved and is subject to a hearing, the carrier's communication should also go to individuals covered under an individual product, and to associations/members. The Committee's previous letter detailed instances where Chapter 176X should be properly construed as including individual products even where only specifying "group" products. In addition, the point of requiring carriers to communicate this

information to covered employers/individuals is to keep them up to date about any possible changes or continuations in the rates that they pay. That is no less important in the case of individual products or in the case of associations/members than it is for group products.

Regardless of the type of entity or individuals covered under a plan, they would all benefit from receiving such notice because it allows them to make informed decisions about their insurance. For example, even though a rate may be disapproved, placing covered individuals/entities on notice of this disapproval alerts them to the possibility that rates may increase at some point in the near future (e.g. if the disapproval were to be overturned at a public hearing).

In communicating to all covered individuals/entities, the carrier should: (1) forward the notice(s) concerning the disapproval of the rate(s) in question and any notice(s) of the public hearing; and (2) separately explain the potential impact that the hearing may have on the rate(s) in question, including the possibility that the rate may increase if the disapproval is overturned at the hearing. Such information should be delivered in the usual and customary manner in which the carrier communicates to its covered individuals/entities, whether by mail, e-mail, or otherwise. It should be conveyed as soon as reasonably practicable by the carrier to its covered individuals/entities, but in any event, no more than a week after the information first becomes available to the carrier.

Given that these communications may be time sensitive (particularly depending on when the public hearing may be scheduled), the Division should not have to review these communications before the carrier sends them out; nonetheless, the Division should reserve the right to review the content of the communications and method of transmission at any time to ensure compliance, and to direct the carrier to make corrections as needed.

2) **What procedures should the Division of Insurance use to conduct a public hearing? What is the timing of the hearing procedures? How should the Division of Insurance advertise the hearing in the papers of the noted cities? What should the Division consider regarding the timing of the hearing?**

The Division should use the standard procedures provided for adjudicatory proceedings as that term is used under M.G.L. c. 30A, §§ 10-12, such as subpoenas, witness testimony, and so forth, as well as the procedures for public hearings under 211 CMR 66.08. Likewise, advertisements for the hearings should comply with those that have been issued under 211 CMR 66.08, with priority on those newspapers with the largest subscribers and those that are viewable online. The Division should adopt the applicable timing requirements under Section 2(g) and additionally should, where feasible, hold the public hearing prior to the effective date for the presumptively disapproved rate.

3) **What is the Attorney General's role in a disapproval hearing? What types of information might the Attorney General staff require to ensure compliance with the subsection?**

The Attorney General's role in the hearing would be the same as under the many other statutes that confer the right of intervention on her: to represent the Commonwealth's interests as

its chief enforcement officer. There is a wide array of additional information that the Attorney General could utilize, depending on the circumstances; for example, the Attorney General could seek additional historical data from the carrier, studies cited by the carrier in its actuarial opinions, and any additional financial information that the carrier may have excluded from its MLR calculations. Given that the necessary information will vary depending on the circumstances, the Committee does not believe that additional regulatory clarification on this point is unnecessary.

SECTION 2(g):

As a general comment, the Committee notes that the disapprovals under Sections 2(c) and 2(g) should largely be treated identically to the presumptive disapprovals under Sections 2(d) and 2(f). The Committee interprets the distinction between presumptive disapprovals and "regular" disapprovals as largely dependent on the degree of discretion afforded to the Division, and not dependent on any other differences. That is, the Division does not have discretion in terms of whether or not it may presumptively disapprove a rate (given the precise calculations involved), but does have a significant degree of discretion in terms of whether or not it may otherwise disapprove a rate (based on whether it is "excessive, inadequate, or unreasonable" or whether it is "discriminatory or not actuarially sound"). As a result, the answers to the following questions largely mirror the answers to various prior questions concerning presumptive disapprovals, except where otherwise noted.

1) **When rates are disapproved for reasons other than the disapproval standards, what should be included in the disapproval notice given to the carrier regarding the noted disapproval reasons? What other information should be included in the notice so that the carrier and other parties are fully aware of the process associated with a disapproval?**

The notice for a disapproval should be substantially similar in content to that described for notices of presumptive disapprovals in the answer to Question 5 under Sections 2(d) and 2(e) (Review Standards) above. However, the statutory text between disapprovals and presumptive disapprovals bears a slight difference that will impact the notice for a disapproval. Specifically, Section 2(f) (presumptive disapprovals) provides that the Commissioner shall conduct a hearing, without any reference to a request for hearing, while Section 2(d) (disapprovals) provides that the carrier "may submit a request for hearing to the division… within 10 days of such notice of disapproval." Thus, a hearing for the former is mandatory/automatic, whereas a hearing for the latter is contingent upon the Division's timely receipt of a request for hearing.

Because of this distinction, the Committee proposes that the initial notice of disapproval should contain the following:

- the reason(s) for disapproval, including an explanation for why the rate was deemed excessive, inadequate, unreasonable, discriminatory, and/or not actuarially sound;
- a citation to the specific portions of Chapter 176X and the regulations thereunder through which the rate was disapproved;
- an explanation of the carrier's right to request a hearing within 10 days of the date of the notice, and how that request may be submitted.

To the extent that the carrier then (timely) submits a request for hearing, the Division should send a second notice containing the following:

- a date/time/location for the public hearing, as well as any other information to access the hearing (such as, for example, Zoom details, to the extent it is held remotely);
- a brief description of the purpose of and procedures available at the public hearing, including witness testimony, etc.;
- a **conspicuous statement** (e.g., in bold, underlined font) of the carrier's obligation to notify those covered under its plan of the hearing.

2) Are carriers permitted to market dental products when they are subject to a hearing? If yes, what would carriers be required to say about the hearing? Are they only permitted to offer rates that are in place prior to the rate filing? If the hearing has not concluded prior to the rates become effective, are the rates required to remain at that level for the duration of the rating year or would carrier be permitted to adjust rates if a disapproval is overturned following a rate hearing conducted according to section 2(g).

Please see the answer to Question 6 under Sections 2(d) and 2(e) (Review Standards) above.

3) If rates are disapproved, should communication go to all employers and individuals covered under the plan that proposed increase has been 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 individual's 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?

Please see the answer to Question 1 under Section 2(f) above.

4) If the carrier elects to submit a request for a hearing within 10 days of a notice of disapproval, how should that notice be forwarded to the Division of Insurance. If the carrier elects to request a hearing, should communication go to all employers and individuals covered under the plan that there will be a hearing on the disapproved rate filing? When should such a notice be forwarded? Should it be sent after a hearing date has been set by the Division so that it may include information about the hearing? 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 individual's 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?

The request for a hearing should be submitted by the carrier to the Division through any customary channels that the Division chooses at its discretion, whether by e-mail, facsimile, mail, electronic portal, or other means. Communication that the carrier has requested a hearing should be accomplished immediately, or in any event no more than a week after the request has been submitted to the Division; this communication should not be delayed pending the Division's scheduling of a hearing date, which can be separately forwarded to the covered individuals/entities once that information becomes available. For the remaining questions, please see the answer to Question 1 under Section 2(f) above.

5) What procedures should the Division of Insurance use to conduct a public hearing? What is the timing of the hearing procedures? How should the Division of Insurance advertise the hearing in the papers of the noted cities? What should the Division consider regarding the timing of the hearing?

Please see the answer to Question 2 under Section 2(f) above.

6) What role might the Attorney General have in a disapproval hearing? What types of information might the Attorney General staff require to ensure compliance with the subsection?

Please see the answer to Question 3 for Section 2(f) above.

7) Are carriers permitted to market dental products when they are subject to a hearing? If yes, what would carriers be required to say about the hearing? Are they only permitted to offer rates that are in place prior to the rate filing? If the hearing has not concluded prior to the rates becoming effective, are the rates required to remain at that level for the duration of the rating year or would carrier be permitted to adjust rates if a disapproval is overturned following a rate or court hearing conducted according to section 2(g).

Please see the answer to Question 6 for Sections 2(d) and 2(e) (Review Standards) above.

Sincerely,

/s/ Matthew Perry

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March 14, 2023

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Re: Altus Dental Insurance Company, Inc.
Comments With Respect To Section 2 (d)-(g) (Discussed At Session #3);
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 (Third) Informative Session, dealing with sections 2(d) through (g) of c. 176X, we respectfully submit the following comments:

As to Section 2(d); "Review Standards", Q. 1-6

• With respect to the standard for measuring the increase in administrative expenses, the statute requires that the "dental services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted)" be used and applied to the increase in the administrative expense loading component/factor, "not including taxes and assessments". It seems clear that the United States Bureau of Labor Statistics Consumer Price Index For Dental Services most closely fits that very precise description.

• The reference to "U.S. city average, all urban consumers" would appear to preclude adjustments for New England, Massachusetts, or Boston metropolitan-area specific costs.

• The "most recent calendar year's percentage increase" should be based on a comparison of the calendar year statistics for the years comprising two consecutive annual rating periods.

• Yes, the Division should calculate and announce this statistic annually so that carriers can be aware of it when submitting rate filings that may be presumptively disapproved.

• The measure of a carrier's compliance with the "contribution to surplus" limitation of 1.9 percent should be based on the industry standard: The percentage by which the surplus itself is proposed to be increased in the rate filing.

• Importantly, the most critical information required to be developed at this time to permit the presentation of how total administrative expenses are projected to increase is regulatory guidance as to which items of expense listed in Section 2(b) are to be included in the actual ***calculation*** of the dental loss ratio, as opposed to ancillary **reporting**. As we have previously commented, M.G.L. c. 176X leaves this determination to the Commissioner. We have previously noted the fundamental unfairness of including within that calculation external broker/consultant fees that are merely passed through the carrier as a courtesy to the customer that engaged the broker/consultant, as well as premium taxes. We note again that taxes are excluded from the calculation under the ACA and most State loss ratios, and that broker commissions and taxes have both been eliminated from the Dental Loss Ratio legislation presently pending in Illinois, the headquarters of the American Dental Association.

• With respect to the manner in which to calculate the "contribution to surplus" limitation for purposes of the presumptive disapproval standard, M.G.L. c. 176X is clear that the increase cannot exceed 1.9 percent. The industry standard is that this means an increase of 1.9 percent of the surplus/reserves.

• We respectfully submit that M.G.L. c. 176X should not be interpreted as repealing or overriding the provisions of 211 CMR 66.00 that provide for different contribution-to-surplus standards for companies that fall below certain financial ratios. The latter are important to the overarching interest in proper regulatory management and avoidance of potential financial crises arising from insurer insolvency.

• As we have previously noted, M.G.L. c. 176X does not contemplate that there would be different medical loss ratio calculation filings for different markets, market sizes, or products. The ratio is to be based on "the aggregate medical loss ratio for all plans offered."

• The "rounding" calculation for the projected dental loss ratio should follow the same standard applicable to the current medical loss ratio filing requirements for Mass Connector products.

• With respect to the manner in which the Division communicates with carriers concerning disapproved rates, we do agree that the Division should provide notice of the

disapproval expeditiously and provide a limited time for rate calculations to be updated/amended before initiating a hearing proceeding.

As to Section 2(e); "Refund Calculations", Q. 1-4

• Consistent with the standard in the ACA and at the state level elsewhere where dental loss ratios have been addressed (New Mexico, for example) the refund calculation should utilize experience over a three-year reporting period to develop an average that is used for comparison to the .83 standard.

• Again, there should not be separate calculations for separate markets, as M.G.L. c. 176X requires the ratio to be based on "the aggregate medical loss ratio for all plans offered". Unlike the ACA, the statute did not provide for a different ratio for large or small group plans.

• There is great danger that enrollment in the small group market dental plans (much of which is voluntary, involves higher administrative costs and is highly price sensitive) is likely to diminish substantially by reason of the DLR as it is. Applying a separate DLR calculation to those plans would only exacerbate that reality.

• Claims runout and retroactive claims generally occur over a 90-day period. We suggest that reference be made to how this issue is handled with respect to the medial loss ratio process already in place.

• Yes, an implementation plan should be filed with respect to not only refunds, but alternatively for a credit on the premiums for the subsequent 12 month period for individuals or groups still covered by the carrier, as specifically provided for in M.G.L. c. 176X. Refunds and credits, as applicable, will be administered at the group level for group business.

• Yes, a carrier should have a $25.00 de minimus standard so they are not required to refund amounts to individuals/groups that fall below the de minimus level. Our analysis reveals that the processing and mailing costs associated with refunds will rival – and in many instances exceed – the amounts of the refunds themselves. A reasonable and practical alternative – such as payment of refunds to a fund for the advancement of dental care access – should be considered.

As to Section 2(f), Q. 1

• The communication that a rate change has been presumptively disapproved should not be required to exceed the notice requirements specifically prescribed by this Section. Notice is to be provided to employers and individuals covered under a group product. The required newspaper notice of the public hearing is for the benefit of any other potentially interested or affected individuals, as is the potential intervention of the Attorney General.

• Where direct notice is required to be provided, it should be allowed to be forwarded by e-mail or, in the absence of an e-mail address, to the individual's last known mailing address. ***As to Section 2(g), Q. 1***

• Where rates are disapproved for reasons other than the presumptive disapproval standards, the disapproval notice should, at a minimum, include a detailed disclosure of the reasons for disapproval; a description of the hearing process; and provisions for a limited time for rate calculations to be update/amended before initiation a hearing proceeding, as discussed above.

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