Chapter 287 of the Acts of 2022

Information Session #3 on Wednesday, February 15 at 1PM – Filing

Section of 1 of Chapter 287 creates Chapter 176X. Section 2 describes the process to file and review rate materials. Session 3 will concentrate on subsections (d), (e), (f) and (g).

Section 2.(d)

"If a carrier files a base rate change under this section and the administrative expense loading component, not including taxes and assessments, increases by more than the most recent calendar year's percentage increase in the dental services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted) or if a carrier's contribution to surplus exceeds 1.9 per cent or if the aggregate medical loss ratio for all plans offered under this chapter is less than the applicable percentage set forth in subsection (e), then such carrier's rate, in addition to being subject to all other provisions of this chapter shall be presumptively disapproved as excessive by the commissioner as set forth in this subsection.

If the annual aggregate medical loss ratio for all plans offered under this chapter is less than the applicable percentage set forth in subsection (e), the carrier shall refund the excess premium to its covered individuals and covered group. A carrier shall communicate within 30 days to all individuals and groups that qualify for a refund that the premium to its covered individuals and groups. A carrier shall communicate within 30 days to all individuals and groups that were covered under plans during the relevant 12-month period or, if the individual or groups are still covered by the carrier, a credit on the premium for the subsequent 12-month period. 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). calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner. The commissioner may authorize a waiver or adjustment of this requirement only if it is determined that issuing refunds would result in financial impairment for the carrier."

Section 2.(e)

"The medical loss ratio set forth in subsection (d) shall be 83 percent."

<u>Review standards</u>

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 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?

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

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 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?

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?

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 Division immediately schedule a hearing when it believes a carrier's filing does not meet a presumptive disapproval standard? Should the Division provide a limited time for rate calculations to be updated/amended before initiating a hearing proceeding?

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 becoming effective, are the rates required to remain at the prior year level for the duration of the rating year or would the carrier be permitted to adjust rates if a disapproval is overturned following a rate hearing conducted according to section 2(f) or (g).

<u>Refund Calculations</u>

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?

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?

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 to have de minimus standards so that they are not required to refund amounts to individuals/groups that fall below the de minimus level? Should the Division of Insurance have the authority to disapprove any plan that does not meet the statutory timelines or does not adequately distribute/credit refunds to members? Should carriers be penalized (e.g., with interest penalties) for refunds that are not properly transmitted to members within the statutory timelines for refunding premiums to members?

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

Section 2.(f)

"If a proposed rate change has been presumptively disapproved:

(i) a carrier shall communicate 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;

(ii) the commissioner shall conduct a public hearing and shall advertise that hearing in newspapers in the cities of Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford, and Lowell, or shall notify such newspapers of the hearing; and

(iii) the attorney general may intervene in a public hearing or other proceeding under this section and may require additional information as the attorney general considers necessary to ensure compliance with this subsection. The commissioner shall adopt regulations to specify the scheduling of the hearing required under this section and to otherwise carry out this subsection (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 correct contact information to send these notices to individuals? What method should be used to deliver the notice to groups and individuals? Are notices to be forwarded by mail, e-mail or other method? Should the notices be reviewed by the Division of Insurance prior to their being sent to groups and individuals? How long after the carrier has been notified that a rate filing has been disapproved should the carrier send the notices to members?

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?

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?

Section 2.(g)

"If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The carrier may submit a request for hearing to the division of insurance within 10 days of such notice of disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverse the disapproval after a hearing or unless a court vacates the commissioner's decision."

1) When rates are disapproved for reasons other than the presumptive 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?

2) 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?