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March 14, 2023

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Re: Altus Dental Insurance Company, Inc.
Comments With Respect To Section 3 (Discussed At Session #4);
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 (Fourth) Informative Session, dealing with section 3 c. 176X, we respectfully submit the following comments:

As to Section 3(a)

• The statue identifies certain market group sizes that should be reported on "where applicable". However, this requirement should not be applicable where a carrier does not have systems in place to track or collect the information in the bands or categories listed because it does not market or rate groups in those bands or categories. To require carriers to undergo expensive cost-accounting system conversions to track and report to this degree – particularly where much of the reporting does not relate to the dental loss ratio calculation itself – would be cost prohibitive and wasteful. It would require substantial additional administrative costs to be expended, which is precisely the opposite of what the statute intends to accomplish. There is great merit in the concept – discussed in Question #3 (under section 3(b) below) – that carriers

that do not have cost accounting systems to allocate costs precisely in the statutory bands or categories should be able to elect to do so through a reasonable alternative consistent method across group size categories and lines of business.

• Group size, to the extent available cost accounting systems are capable of tracking it, should be based not on the number of "eligible" members, but on the number of members. We have no way of knowing the number of "eligible" members a group has that are not actively enrolled with us.

As to Section 3(b)

• We do not have cost accounting systems that track or report the following items at the group or individual level or by line of business – only at the carrier/company level, and we could not do it in any event: (vi) realized capitalized gains and losses; (vii) net income; (viii) accumulated surplus; (ix) accumulated reserves; (x) risk-based capital ratio. We also do not have cost accounting systems to track or report separately on items (xi) through (xxi). at the individual, group or line of business level, but would have to allocate across our overall enrollment.

As to Section 3(c)

• As regards self insured business, the same comments expressed above in terms of the inability to track, report, or cost-account also apply to separately accounting for self insured business.

• Moreover, self insured business is not covered by M.G.L. c. 176X. ERISA would in all events preempt any such application.

• Yes, it is clear that, even if it were *possible* to cost-allocate as between insured and self insured business, only Massachusetts "members" – *i.e.*, subscribers and their dependents – should be counted.

• No premium or loss ratio calculations should be required to be reported. There is no "premium" for the group, and hence no loss ratio to be calculated. Moreover, self insured business is not covered by M..G.L. c. 176X, and application of the statute to self insured business would likely be preempted by ERISA, as it is not "insurance" subject to State regulation.

• Mandated benefits should not have to be reported on, or should be allowed to be reported on as "not applicable" -- as there are, as noted by the Division, no mandated dental benefits.

As to Sections 3(d), (e), (f)

- We have no comments on these sections or the corresponding questions.

Thank you for this opportunity 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

ROSEN & GOYAL, P.C.

March 14, 2023

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

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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 March 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.

Before answering specific questions, the Committee notes that, generally, Section 3 of Chapter 176X utilizes much of the same language as a prior version of M.G.L. c. 176O, § 21 (effective until August 2018). Accordingly, the Division should interpret identical language in Section 3 as it did under the aforementioned prior version of M.G.L. c. 176O, § 21, except where otherwise noted.

The Committee further wishes to respond to a general comment on the usefulness of Section 3. It was suggested during the information session that the prior version of M.G.L. c. 176O, § 21 was repealed because it was either not useful or overly burdensome to carriers. Regardless of the precise reasoning as to why certain provisions in M.G.L. c. 176O, § 21 were repealed, this does not mean carriers can ignore the law under Chapter 176X. It is the Committee's position that the retrospective information requested under Section 3 is an important supplement to the prospective information required by Section 2(b), in order to give the Division the information it needs to ensure compliance with the law as a whole. Indeed, the SJC noted as much when it stated that "the common purpose of the two sections is apparent from the way they complement one another. Clark v. Att'y Gen., 489 Mass. 840, 846 (2022). Section 3, as the court explained in further detail, prevents accounting abuses by carriers. Id. at 847.

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As for the burden associated with Section 3, given the substantial overlap in the categories of information requested between Section 2 and Section 3, the Committee believes any such burden is overstated. Nonetheless, it should be noted that under Section 3(d), the Division must "ensure that the reporting requirements imposed under the regulations are not duplicative." This would further insulate carriers against any allegedly undue burden. With that said, the Committee answers the questions posed by the Division on Section 3(a) – Section 4 of M.G.L. c. 176X as follows:

SECTION 3(a):

1) **Is it clear that that the reporting requirements apply to all markets in which the dental carrier issues coverage in Massachusetts? Is it clear that the reporting requirements are not intended to include any information for coverage issued in any jurisdiction outside Massachusetts?**

It is clear that the reporting requirements apply to all markets. As for coverage issued outside of Massachusetts, please see the Committee's response in its February 13, 2023 letter to question 2 under Section 2(a). Again, dental and health benefit plans should be treated the same in this regard.

2) **Regarding reporting by group size, are all the reporting categories clear? Should the reporting group size be based on the number of subscribers eligible within a group, regardless of the state in which the members of the group live?**

All reporting categories are clear. The reporting group size should be regardless of where individuals live, as there are scenarios where individuals residing in other states would need to be factored in (for example, where a subscriber resides in Massachusetts but his/her dependent resides in another state).

3) **How should group associations/trust be reported in this section according to market group size; should they be reported according to the size of the eligible pool in Massachusetts or nationally?**

Reporting by group size should be done in the same manner as in response to Question 2 above. That is, group size should be dictated by the number of eligible individuals under a group association plan, and not through some other unit of measurement, such as the number of employers within the group association plan.

4) **Is it clear that carriers should report separate statistics for lines of business? Should information be reported separately for open network, preferred network and closed network products? Should information be reported separately for Medicare and Medicaid products? It is noted that information is to be reported for stand-alone dental plans issued by the Group Insurance Commissioner (chapter 32A); should these plans be reported separately as its own line of business?**

It is clear that carriers should report separate statistics for lines of business. Information should be reported separately for open/preferred/closed network products, and separately for Medicare/Medicaid products. Carriers should not be permitted to mask shortcomings with respect to rates for one product by blending the statistics for that product with statistics for other products.

5) **Is it clear that carriers should report separately for each company offering coverage in Massachusetts, even if the companies are part of a family of coverages?**

Yes, it is clear. The reporting requirements are directed to "[e]ach carrier" rather than groups of affiliated entities.

SECTION 3(b):

1) **Is it clear that each of the listed items are to be reported for each company, each line of business and for each group size category in the reporting information? For example, the loss ratio, members and groups and net income should be reported separately for each company, line of business and group size category?**

Yes, this is clear. Again, carriers should not be permitted to mask shortcomings with respect to rates for one product, market, or business by blending the statistics for that product, market, or business with statistics for other products, markets, or businesses.

2) **How should accumulated surplus, accumulated reserves and risk-based capital be reported in this report? Should carriers attempt to report a separate risk-based capital score for each company, line of business and group size category or should one number be reported for each company and not by line of business or group size category?**

Accumulated surplus, accumulated reserves, and risk-based capital should all be reported as part of a carrier-wide balance sheet. Risk-based capital ("RBC") should also be calculated in accordance with the procedure established under 211 CMR 25.00 et seq. and NAIC methodology. The Committee acknowledges that certain financial information—such as RBC levels—are not conducive to reporting at the level of individual lines of business/group size. Thus, in such instances, a carrier would need only to report the same RBC across all lines of business and all group sizes. This is why the law clarifies that the financial information must be itemized by group size or line of business "where applicable." Here, it would not be applicable.

3) **What methods should carriers use to allocate the administrative expenses identified in items (xi) – (xxi) across companies, lines of business and group size categories in the reports when they may not have any cost accounting systems that record these expenses as noted? Should a consistent method be used across the reporting carriers or should carriers choose the best method based on their accounting systems and use this consistently throughout their report?**

The Division should require all carriers to consistently use a singular, standardized, and widely accepted accounting method of its choosing. Regardless of the particular method adopted, consistency is crucial. Carriers should not be allowed to decide at their own discretion what particular method to adopt. Allowing such discretion would prevent data comparisons across different carriers, and therefore defeat an important aspect of collecting such data in the first place.

Additionally, carriers should default to reporting a particular administrative expense across all lines of businesses, and across all group sizes, unless that administrative expense is explicitly and solely targeted at particular line(s) of business and/or group(s), or the administrative expense could otherwise not logically be connected to certain line(s) of business and/or group(s). For example, a commercial for a carrier that does not identify a particular product or group as its target should be reported across all lines of business/groups, whereas a commercial for a particular product and/or group could be limited to said product/group.

SECTION 3(c):

1) **Is it clear that carriers with insured members are to complete the report for this section for any dental business that they administer in Massachusetts as a third-party administrator for self-funded accounts? Is it also clear that those entities that only operate as third-party administrators for self-funded accounts are also to complete this report for any dental business that they administer in Massachusetts? Is it clear that this report should not include any self-funded employer dental business for an employer that is not administering benefits from Massachusetts?**

It is clear that carriers must complete the report for Section 3(c) for any dental business that they administer in Massachusetts as a third-party administrator for self-funded accounts, **provided** that they separately offer dental benefit plans in the Commonwealth for which they do **not** act as a third-party administrator. Carriers that **only** operate as a third-party administrator, and do not have at least one other dental benefit plan for which they do **not** act as a third-party administrator, are not required to complete the report for Section 3(c).

It was suggested by some at the latest information session that there appears to be an "internal contradiction" in M.G.L. c. 176X, in that (on the one hand), Section 3(c) concerns self-insured groups while (on the other hand) Section 4 excludes self-insured groups. To be clear, there is no contradiction. The language of the law must be examined closely. Section 3(c) applies to carriers otherwise "**required to report under this section**." Section 4 indicates that Chapter 176X "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."

As the Division is undoubtedly aware, a carrier may wear different hats. For some clients, a particular carrier may be acting solely as a third-party administrator, while for other clients, that same carrier may be acting in its full capacity as an insurer. With that and the foregoing cited language in mind, it becomes clear how Section 3(c) and Section 4 can be reconciled: The only carriers that are "required to report" under Section 3(c) are any entities that fit the definition

of a carrier, other than those that act **solely** as a third-party administrator for all of their client(s).

For those carriers that have a mix of clients (i.e., where the carrier is serving as a third-party administrator in some cases, and as a full insurer in other cases), they are required to report under Section 3(c). The purpose of this section is borne of necessity. Without the appendix for self-insured group data under Section 3(c), there would be no way of verifying if a carrier (whether inadvertently or deliberately) has combined data from its self-insured groups with data for its fully-insured groups. Thus, Section 3(c) offers a holistic picture of the financial data for these carriers with a mix of clients, to ensure full transparency and that they are complying with other provisions of the law. The reporting for self-insured groups under Section 3(c) is simply incidental to achieving that goal.

2) **Is it clear that the number of the carrier's self-insured dental customers should only include those customers who coordinate employer-sponsored dental plan benefits in Massachusetts? Is it also clear that the number of members should only include employee subscribers of those employers whose benefits are coordinated out of Massachusetts? Is it also clear that the number of covered lives should not include the subscribers and their dependents who are in self-funded dental plans that are administered outside of Massachusetts?**

Provided that when the Division says, in the second question, "out of Massachusetts," the Division means "in Massachusetts," then yes, all of these are clear. The Committee further notes that the definition of a third-party administrator under the law is specifically limited to "residents of the commonwealth."

3) **What should be reported for premium and loss ratio? As third-party administrators for self-funded plans, these entities may collect administrative fees, but not premiums in the course of their administration of self-funded accounts. Also, since these third-party administrators are not collecting premium, what should be reported for loss ratio?**

These items should be calculated as they are elsewhere in the law, and reported just as they are under 211 CMR 148.04.

4) **What should be reported for net income? Should this represent the difference in the administrative service fees for dental business paid by self-insured customers and the cost of administering this self-funded business? Should the Division of Insurance also collect information about the cost of administering the self-funded dental business?**

Yes, in the context of Section 3(c), net income should represent the difference between the administrative service fees paid by self-insured customers and the cost of administering the self-funded business. Further, the Division should collect information about the cost of administering the self-funded dental business as "(xi) any other information deemed necessary."

5) **What should be reported for accumulated reserve and accumulated surplus?**

As previously noted above, accumulated reserves and accumulated surplus are reportable on an entity-wide basis. Accordingly, accumulated reserves and accumulated surplus should be reported and treated the same under Section 3(c) as they are reported/treated under Section 3(b). The Division may wish to consult 211 CMR 148.02 and 211 CMR 149.06 to determine what should be reported for accumulated reserves and accumulated surplus.

6) **What should be reported for the percentage of individuals who satisfy Massachusetts mandated benefits? The Division already captures this information in a report associated with M.G.L. c. 176O for mandated health benefits. Since there are not any current mandated dental benefits, should there be anything reported for this item?**

It should be noted that item (ix) in Section 3(c) calls for reporting on the benefits mandated for "health" benefit plans, rather than dental benefits. That said, to the extent that the Division believes that this information is already sufficiently captured under M.G.L. c. 176O, the Committee believes that it may opt not to require carriers to report anything for item (ix), as the law separately provides under Section 3(d) that the Division must "ensure that the reporting requirements imposed under the regulations are not duplicative."

7) **What other information should be collected by the Division of Insurance?**

As described in an earlier section, the Division should collect information about the carriers' cost of administering the self-funded dental business. While the Committee does not proffer any other information to be collected by the Division at this time, the Committee would like to take this opportunity to further detail some of its proposed definitions that were the subject of the Division's first information session. Please see the attached **Addendum: Definitions Supplement** for further information.

In closing, the Committee members have greatly appreciated the opportunities that the Division has provided over the last several weeks, both to answer any question that the Division has about proposed regulations, and to otherwise participate in the public sessions on Chapter 176X. The Committee reiterates (as Dr. Rizkallah has stated at the public sessions) that, given the general complexity of this area of the law, the Division may wish to consider informally circulating successive iterations of the draft regulations among the relevant stakeholders (prior to the formal public hearing under M.G.L. c. 30A), as this could be an effective means of receiving critical feedback.

If the Division has any further questions, either about any of the topics previously discussed, or about any other issue regarding Chapter 176X, the Committee will gladly contribute. Otherwise, the Committee looks forward to and will await further opportunities to participate in the regulatory process.

Sincerely,

/s/ Matthew Perry

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

ADDENDUM:
DEFINITIONS SUPPLEMENT

This addendum is intended to supplement the Committee's January 30, 2023 response to questions posed by the Division concerning definitions under Chapter 176X. Broadly, the Committee presents four categories of proposals for defining terms under Chapter 176X:

I. Existing statutory definitions sufficiently defined within Chapter 176X;
II. Terms referenced/defined in existing Division regulations;
III. Existing regulatory definitions that require alteration; and
IV. Proposed new regulatory definitions/clarifications.

I. EXISTING STATUTORY DEFINITIONS SUFFICIENTLY DEFINED BY CH. 176X:

Category I includes all of the terms in Section 1 of Chapter 176X:

(1) Carrier;
(2) Commissioner;
(3) Connector;
(4) Dental benefit plans;
(5) Self-insured customer;
(6) Self-insured group; and
(7) Third-party administrator.

While additional definitions are unnecessary, it may be prudent for the Division to reiterate the statutory definitions for these terms in its regulations.

II. TERMS REFERENCED/DEFINED IN EXISTING DIVISION REGULATIONS:

Category II terms, and their corresponding regulations, include the following:

(1) accumulated reserves (see 211 CMR 149.06);
(2) accumulated surplus (see 211 CMR 149.04);
(3) claims operation expenses (see 211 CMR 66.08);
(4) distribution expenses (see 211 CMR 66.08);
(5) financial administration expenses (see 211 CMR 66.08);
(6) group product base rates (see 211 CMR 66.03, "Group Base Premium Rates");
(7) marketing and sales expenses (see 211 CMR 66.08);
(8) medical administration expenses (see 211 CMR 66.08); and
(9) network operations expenses (see 211 CMR 66.08).

Any necessary revisions to these terms are self-evident; for example, to the extent that any of the foregoing definitions reference the terms "medical" or "health," the Committee may wish to consider revising these terms to "dental," where applicable. Additionally, as previously noted in a prior letter by the Committee, it should be clarified that "group product base rates" includes rates for individuals. To the extent that any of the foregoing terms are not defined, it is

the Committee's position that any further definition is not required, as their plain meaning can be understood from the context in which they appear.

III. EXISTING DIVISION REGULATORY DEFINITIONS THAT NEED ALTERATION:

For Category III, the Committee proposes the following revisions:

- Group Rating Factors: The definition of a Rating Adjustment Factor under 211 CMR 66.03, which can be adopted for a definition of Group Rating Factors, is "[a] factor permitted by state law and by the Center for Medicare & Medicaid Services that is applied to a Group Base Premium Rate to derive the premium that is charged to a particular [individual] or [employer]." The Committee suggests removing the clause "permitted by state law and by the Center for Medicare & Medicaid Services." Since dental benefit plans were originally exempted from both state and federal MLR requirements, this clause is irrelevant, or at best redundant with respect to state law.

- Net Income: The Committee proposes the following bracketed change to the definition of net income under 211 CMR 149.06 - "direct premiums earned less direct claims incurred [plus direct claims reversed (recaptured from provider)] less expenses plus investment gains and losses." The Committee is concerned that certain income may not be reportable under the existing definition of net income, particularly where (for example) the carrier has obtained an overpayment recovery from a provider. Thus, including direct claims reversed (meaning, claims that were originally paid to a provider but subsequently paid back to the carrier) avoids this potential pitfall.

- Charitable Expenses: The definition of charitable expenses under 211 CMR 66.08 is "[a]ll contributions to tax-exempt foundations and charities, not related to the company business enterprises." The Committee suggests removing the clause "not related to the company business enterprises" from this definition, as it believes this clause may be used by carriers to mask certain expenses that are properly reportable as charitable expenses.

IV. PROPOSED NEW REGULATORY DEFINITIONS/CLARIFICATIONS:

For Category IV, the Committee proposes the following definitions or clarifications:

- Administrative Expense Loading Component (not including taxes and assessments): the amount included in the premium charged by a carrier, on a per member per month basis, to cover its administrative expenses, including: (i) financial administration expenses; (i) marketing and sales expenses; (ii) distribution expenses; (iii) claims operations expenses; (iv) medical

administration expenses; (v) network operations expenses; (vi) charitable expenses; (vii) payroll expenses; (viii) expenses for general administration; (ix) expenses for capital costs and depreciation; and (x) other expenses for miscellaneous expenditures.

- Contribution to Surplus: the amount included in the premium charged by a carrier, on a per member per month basis, intended to go towards the carrier's surplus, i.e. the amount by which the carrier's assets exceed its liabilities.

- Incurred Claims: Although the Committee does not propose an alternative definition for an Incurred Claim as that term is commonly used in the MLR context (see, e.g., 211 CMR 147.02; 45 C.F.R. § 158.140), the Committee believes that a ***critical*** point of clarification should be made in the Division regulations: For purposes of inclusion in the numerator of MLR calculations, Incurred Claims must only include payments ultimately received by the provider for dental services. This means that payments *meant* for the provider and not *received* by the provider (such as payments made directly to patients that do not reach the provider) are not counted in the numerator. Fraudulent losses of this type are part of an insurance company's fraud administration expense.

    - Note that a payment cannot truly be considered a reimbursement for health services unless and until the provider is actually reimbursed. Indeed, 45 C.F.R. § 158.140 indicates that incurred claims "must include direct claims **paid to or received by providers**."

- Quality Improvement Activity (QIA):[1] an activity designed to improve health/dental quality that is performed equitably by or through a provider to all patients, and that meets all of the requirements of 45 C.F.R. § 158.150(b). A QIA does not include any expenditures or activities that are identified under 45 C.F.R. § 158.150(c), that have any overlap with administrative expense items specified under Section 2(b)(i)-(x), that have any marketing component that displays the name of the carrier, or that are paid for by the carrier to any affiliate of the carrier in any way, either directly or indirectly. QIAs may not exceed 1% of premium revenue.

[1] Please see the Committee's prior letter dated February 13, 2023 for additional information on QIAs.