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Concerning Fees that Dental Services of Massachusetts, Inc., d/b/a Delta Dental Plan of Massachusetts, Pays Participating Dentists and the Method Used to Determine Such Fees Pursuant to M.G.L. c. 176E, § 4

Docket No. G2008-10

Decision and Order Regarding the Fee Methodology of the Delta Dental Premier Plan

I. Introduction and Procedural History

On December 18 and 22, 2008, the Division of Insurance ("Division") held a hearing, pursuant to the authority granted to the Commissioner of Insurance ("Commissioner") under Section 4 of M.G.L. c. 176E ("c. 176E"), concerning the fees that Dental Service of Massachusetts, Inc., d/b/a Delta Dental Plan of Massachusetts ("Delta"), pays participating dentists and the method used to determine such fees ("Delta's fee methodology"). The hearing began with an opportunity for public comment. Those who wanted to provide oral or written testimony of a factual or expert nature were required to submit it by sworn oral testimony or by sworn affidavit. The persons who provided comment or testimony are listed in Appendix A.

Delta is a Massachusetts non-profit dental service corporation authorized to do business under the provisions of c. 176E. Since c. 176E was enacted in 1962, only Delta has incorporated

under its provisions.¹ Although formed under c. 176E on September 1, 1966, Delta did not commence business in the Commonwealth until January 1, 1970.² Originally affiliated with Blue Cross and Blue Shield of Massachusetts, Inc. in a joint underwriting and administrative agreement, Delta began operating as a separate entity in 1986.³ Under Delta's dental service plans, some or all of the cost of dental services furnished to subscribers and covered dependents is paid by Delta directly to registered dentists who agree, in writing, to be participating dentists and to abide by Delta's by-laws, rules and administrative procedures. M.G.L. c. 176E, § 1. Participating dentists accept Delta's reimbursement without balance billing subscriber-patients, except for copayments, deductibles or non-covered benefits. The Commissioner has authority, under Section 4 of c. 176E ("§ 4), to oversee the method of determining the fees to be paid to such participating dentists:

The fees to be paid to participating dentists for their services to the subscribers or to insured dependents, or the method of determining such fees, shall at all times be subject to a public hearing as provided by section two of chapter thirty A and to the written approval of the commissioner. Such fees shall not be equal to or higher than the fees charged by participating dentists to their average nonsubscriber patients; and in consideration of said fees submitted for his approval, he shall give weight to the ease and certainty of collection by the participating dentists of said fees charged subscribers through such corporation.

Under § 4, the Commissioner undertakes to ensure that fees paid to participating dentists fall within a range of reasonableness and that the method of determining such fees is reasonable, considering the costs of running a dental practice.⁴ Chapter 176E does not address consumer costs for dental care.

¹ 1962 Mass. Acts, c. 714.

² See *Opinion, Findings and Decision on Proposed Method of Reimbursing Participating Dentists*; Docket No. 79-4-1, filed in May 1979; submitted in this docket as Delta Exhibit 3.

³ See *Decision on Request of Massachusetts Dental Society to Disapprove Inclusion of Five Percent Discount in Provider Fee Methodologies*, Docket Nos. R96-28 and R96-29, filed on March 11, 1998 ("*1996 Decision*"), page 4, note 3.

⁴ The Commissioner's approval power over the fees and fee methodologies of c. 176E dental service corporations logically is related to the unique non-profit nature of such corporations. The intention of the statute to link c. 176E dental service corporation fees and fee methodologies to the realities of the costs of running a dental practice is

II. Scope of the Hearing and Scope of this Decision

Although Delta offers a number of products in Massachusetts, Delta provided information and testimony at the hearing only about the Delta Dental Premier Plan (“Premier”). When asked about the limited scope of its presentation, Delta asserted that its products other than Premier are exempt from the application of c. 176E, including review under § 4. Delta’s assertion is surprising, because the fees paid to dentists under its DeltaPreferred Option product, a preferred provider plan, were reviewed as part of a Division hearing as recently as 1996. See *Decision on Request of Massachusetts Dental Society to Disapprove Inclusion of Five Percent Discount in Provider Fee Methodologies*, Docket Nos. R96-28 (Delta Dental Plan of Massachusetts Proposed Fees for DeltaPremier Network) and R96-29 (Delta Dental Plan of Massachusetts Proposed Fees for PPA Providers under DeltaPreferred Option Product), filed on March 11, 1998 (“1996 Decision”). With respect to Delta’s preferred provider products, M.G.L. c. 176I, § 9 provides in its first sentence that “[a]n organization which offers or administers a health benefit plan . . . under a preferred provider arrangement shall be subject to all of the provisions of its enabling or licensing statute and of any other provisions of the general laws applicable thereto . . .” Delta’s enabling or licensing statute is c. 176E, and the expansive definition of “participating dentist” in Section 1 of that chapter manifests the broad scope of the Commissioner’s § 4 review.⁵ Participating dentists who are reimbursed through Delta’s preferred provider plans, including those who participate in DeltaCare, its capitated plan, fit within the ambit of this statutory definition, regardless of the terminology Delta uses in its plans to describe them, and such plans are subject to the Commissioner’s review pursuant to c. 176E, § 4.

Delta also asserted that a new hearing notice would be required if the Division intended in this proceeding to review its fee methodology for any products other than Premier. The hearing notice for this proceeding, however, was not limited to Premier; it stated that “[t]he

evident from the statutory linkage of such fees and methodologies, in part, to the ease and certainty of payment by such corporations to participating dentists.

⁵ M.G.L. c. 176E, § 1 defines a “participating dentist” as “a registered dentist who agrees in writing with a dental service corporation to perform dental service for subscribers and covered dependents and to abide by the by-laws, rules and regulations of such corporation.”

hearing will address all products currently marketed by Delta Dental in Massachusetts to the extent that they involve M.G.L. c. 176E, § 4 fees.”⁶ Delta’s other plans, however, appear to have fee methodologies radically different from that used for Premier, and could only be evaluated after submission of data and testimony specific to each plan, with attendant delay. See, e.g., Delta Exhibit 9. In the interest of administrative efficiency, therefore, I defer review of the fee methodologies used in Delta plans other than Premier to the future, to avoid delay in issuing a decision about Premier. This decision will address only Delta’s fee methodology for Premier, as the title of this Decision and Order makes clear.

III. The Premier Fee Methodology⁷

Delta uses a “usual and customary” fee approach for Premier, which involves a catalogue of fees for each dental procedure. The catalogue uses 294 different dental procedure codes for the various dental procedures. Delta updates its Premier fee catalogue every six months. The Premier fee methodology consists of a series of comparisons, with the lesser fee from each pairing constituting the fee based on which the dentist will be paid, subject to further reduction based on another comparison in the series. A Premier participating dentist for a particular procedure is paid based on the lower of his or her (1) submitted fee or (2) “profile fee.” A Premier participating dentist’s “profile fee” for a procedure is the lesser of (1) the dentist’s own “usual fee” for that procedure or (2) the “customary maximum allowable fee” for that procedure. The “customary maximum allowable fee” for a procedure is either (1) the “customary fee,” which is set at the 90th percentile of all dentists’ “usual fees” for that procedure during a “study period,” or (2) the prior update’s “customary maximum allowable fee” adjusted by reference to a consumer price index (“CPI”). In every case, at the time of processing the claim and making

⁶ This language appeared in both the Notice of Hearing dated October 29, 2008, published in the *Boston Globe* on October 31, 2008, and in the earlier Notice of Hearing, dated October 21, 2008, published in the *Boston Globe* on October 24, 2008.

⁷ My findings about Premier’s fee methodology rely primarily on the sworn testimony of Fay Donohue, President and Chief Executive Officer of Delta; Elizabeth Leonin, Director of Underwriting for Delta, and Guy Mandel, Delta’s Director of Operations. I could not reconcile the fee methodology described by them with the approach to fee-setting that was depicted by Dr. Williams, Delta’s Chief Dental Officer (Tr. 69): “We at Delta Dental actively monitor our competitors’ fees using information that’s publicly available that we can find. Based on that information regarding the competitors’ fee levels, the Premier fees are positioned within the spectrum of fees paid by the various insurers.”

payment, Delta applies a 5% discount to the portion of the fee that it is paying.⁸ Delta states that this 5% discount is justified by the “ease and certainty” of its payment to the dentist, a term that appears in M.G.L. c. 176E, §§ 4 and 7.⁹

For each six-month update of Premier’s catalogue of fees, Delta establishes a “usual fee” for each participating dentist for each procedure that dentist performs.¹⁰ Delta arrays the claims a dentist submitted to it for payment over a prior six-month period (“the study period”) from the lowest to the highest. The fee that is at the 60th percentile is that participating dentist’s Premier “usual fee” for that procedure for the ensuing six-month period. For its April update, Delta uses the fees submitted by a participating dentist for the previous April through September; for its October update, the study period is from the previous October through March. Delta’s update of its fee catalogue for Premier in October 2008, accordingly, was based on fees submitted by participating dentists from October 2007 through March 2008. The oldest data used to set Premier’s fee catalogue therefore is 12 months old at the beginning of the period of its use and is 18 months old at the end of its use. Ms. Leonin explained that Delta uses the 60th percentile approach because it views this as the fee that a dentist charges the majority of his or her patients for the six-month study period.¹¹

Delta also establishes a “customary fee” for each dental procedure as part of its six-month update of Premier’s catalogue of fees. The “customary fee” for each procedure lies at the 90th percentile of all participating dentists’ “usual fees” for that procedure, arranged in numerical

⁸ The most common Delta plan design incorporates a “100-80-50” model, covering preventive care, such as a dental cleaning, at 100%; basic restorative care, such as a filling or root canal, at 80%; and major restorative procedures, such as crown and bridgework, at 50%. This 100-80-50 model is the most common foundation for Delta plan designs; about 76% of the plans in Delta’s book of business have this coverage model. The 80% and 50% nomenclature potentially is confusing to subscribers. See discussion at Section IV.C of this decision.

⁹ In contrast to Premier participating dentists, who are paid directly by Delta, when a Delta subscriber is treated by a non-participating dentist, the patient pays the dentist and Delta, in accordance with M.G.L. c. 176E, § 7, reimburses the patient for some of the cost of the procedure.

¹⁰ The Premier concept of a participating dentist’s “usual fee” should be distinguished from the statutory term “usual fee” in the second paragraph of M.G.L. 176E, § 7, which, in that paragraph “means the fee usually charged by a nonparticipating dentist for substantially similar services to patients who are not subscribers or covered dependents of a dental service corporation.”

¹¹ See discussion at Section IV.A of this decision.

order, from lowest to highest.¹² Whether the Premier “customary fee” amount is the value used in the “profile fee” comparison with a particular dentist’s “usual fee” depends on a calculation involving a CPI.

Since April 1, 1990, Delta has calculated a number by multiplying the prior update’s “customary maximum allowable fee” for each of the 294 dental procedure codes by the increase in a CPI, and then has compared this number to the “customary fee” for each procedure for that update. The new “customary maximum allowable fee” for the current update of the catalogue of fees will be the lesser number. In this way, increases in the “customary maximum allowable fee” from period to period potentially are capped by reference to a CPI. Typically the “customary maximum allowable fee” is set at the existing “customary maximum allowable fee” adjusted by the CPI.¹³ For example, Delta testified that the Premier “customary maximum allowable fees” that became effective on April 1, 2008 for 293 of the 294 procedure codes were set by reference to the pre-existing “customary maximum allowable fee” from the prior update, adjusted by the increase in the CPI, rather than at the “customary fees” based on data from the update’s study period.¹⁴

¹² Delta uses several names when referring to Premier’s “customary” methodology, including the “customary fee,” the “customary maximum,” the “maximum fee,” or the “maximum allowable fee.” More clearly differentiated terminology, however, facilitates understanding of the Premier fee methodology. I therefore have adopted more precise nomenclature in the descriptions that follow, employing terminology used by Delta but limiting a variation to only one aspect of Premier’s “customary” methodology. I have used the term “customary fee” to refer exclusively to that aspect of Premier’s “customary” methodology that is directly based on the “usual fees” charged by dentists during a study period. I have used the term “maximum allowable customary fee” to refer solely to the lesser number when (1) the number based on these “usual fees” is compared to (2) the “maximum allowable customary fee” amount for the prior update as adjusted by a CPI. My terminology was prompted by Ms. Leonin’s testimony at Tr. 44-45. She testified at Tr. 44 that “[t]he customary fee is within the 90th percentile of all participating dentists’ fees for each procedure.” Delta has not always used a 90th percentile approach in its “customary” methodology. In 1976 Delta filed for a change in the method of reimbursing participating dentists from the mean plus one standard deviation to the 90th percentile method for its “customary” payment methodology. See Opinion, Findings and Decision on the filing by Dental Service Corporation of Massachusetts, Inc. to change the Method of Reimbursing Participating Dentists, filed on June 25, 1976, submitted in this docket as Delta Exhibit 2.

¹³ Delta describes the process at page 4 of the “Post-hearing Statement of Delta Dental of Massachusetts,” filed on January 16, 2009 (“Delta’s Post-hearing Statement”).

¹⁴ This means that for the April to September 2008 period the “customary maximum allowable fee” for more than 99.6% of the procedure codes was set based on CPI adjustment of the prior period’s “customary maximum allowable fee.”

Delta uses the Consumer Price Index – All Urban Consumers (Not Seasonally Adjusted) for the Boston-Brockton-Nashua, MA-NH-ME-CT for All Items, prepared by the United States Department of Labor’s Bureau of Labor Statistics as its fee-capping yardstick (“Delta’s CPI” or “the CPI”). Delta’s CPI reflects the cost to an urban consumer of purchasing a basket of goods and services on a retail basis. The major categories of goods and services measured by the Bureau of Labor Statistics for this CPI include food at home, food away from home, utilities, household furnishings, apparel, transportation, motor fuel, medical care, education and recreation. The prices that consumers pay for services billed by dentists are included in Delta’s CPI under the category of medical care.

In her March 6 Affidavit, Ms. Donohue describes the effects of the various components of the Premier fee methodology, based on a review of fees submitted by Premier participating dentists from January 1, 2008 through November 30, 2008. That analysis, which approximated the fee reductions associated with the components of the Premier methodology during that period, showed that dentists’ submitted fees were reduced on a percentage basis as follows: (1) 2.2% by the 5% discount;¹⁵ (2) 0.8% by the use of the “usual fee” methodology, exclusive of the 5% discount; (3) 0.001% by the use of the “customary fee” methodology, exclusive of the CPI cap; and (4) 11.2% by the application of the CPI cap.

IV. Analysis and Conclusions

A. Compliance with the Statutory Mandate of M.G.L. c. 176E, § 4

M.G.L. c. 176E, § 4 requires that the fees paid by a c. 176E dental service corporation to participating dentists for their services to its subscribers “shall not be equal to or higher than the fees charged by participating dentists to their average nonsubscriber patients” (“the statutory mandate”). To determine what fees are charged by Premier participating dentists “to their average nonsubscriber patients,” Delta collects the fee charges submitted to it by participating dentists for services provided to Delta subscriber-patients. Delta’s contracts with Premier participating dentists require them to charge Delta patients the same fees that they charge nonsubscriber patients. By collecting the fee information submitted for Delta patients, therefore,

¹⁵ This is the percentage reduction from Premier participating dentists’ submitted fees. As has been stated, the portion of the total fee that is paid by Delta is reduced by 5%.

Delta determines what its participating dentists charge their nonsubscriber patients. To assure compliance with this contractual obligation, Delta audits Premier participating dentists.

As a practical matter, Delta asserts that it has to rely on the approach it uses for ensuring compliance with the statutory mandate because, as Ms. Leonin explained, Premier participating dentists would not have submitted claims involving nonsubscriber patients to Delta for processing during a study period. Delta has persuaded me that its data collection approach is reasonably designed to obtain the data necessary to form a fees benchmark by which to ensure compliance with § 4. Delta has shown, furthermore, that its current fee methodology ensures that its fee payments to Premier participating dentists for services provided to Delta patients are not equal to or higher than the fees they charge their average nonsubscriber patients.

B. The 5% Discount for “Ease and Certainty of Payment”

M.G.L. c. 176E, § 4 directs that the Commissioner “in consideration of said fees submitted for his approval, . . . shall give weight to the ease and certainty of collection by the participating dentists of said fees charged subscribers through such [M.G.L. c. 176E dental service] corporation.”¹⁶ Delta has identified its 5% Premier discount specifically with the benefit realized by participating dentists because of the “ease and certainty” of payment by Delta. Whether a participating dentist is being paid based on the dentist’s actual submitted fee or the dentist’s “profile fee” for a procedure, Delta has stated that its payment to the dentist is subject to a 5% discount for ease and certainty of payment at the time the claim is processed. The 5% discount applies only to Delta’s portion of a payment because the ease and certainty of payment by Delta is the basis for the discount.

¹⁶ In some of its submissions, the Dental Society seems to presume that Delta may discount its products solely to reflect the ease and certainty of payment by Delta to participating dentists. This reads something into the statute that is not there. The § 4 language does not prohibit c. 176E dental service corporations from incorporating discount features or reductions into its products that are not related to the ease and certainty of payment, as Delta has done. For example, it is rational to regard a participating dentist’s acceptance of dental insurance, with its accompanying responsibilities, as a marketing cost of the practice, as Dr. Williams and Mr. Takacs suggest. A c. 176E dental service corporation such as Delta reasonably could choose to discount its payments to participating dentists as a *quid pro quo* for this benefit. Another benefit that a c. 176E dental service corporation could cite to justify a discount is the increased likelihood that an insured patient will seek dental care and follow-through with a dentist’s recommendations for further treatment.

The statutory concept of “ease and certainty of payment” is linked solely to payments that Delta, as a c. 176E dental service corporation, makes to participating dentists: “the ease and certainty of collection . . . through such corporation.”¹⁷ Delta’s observation that its 5% discount produces lesser reductions of a participating dentist’s aggregate fee depending on whether Delta is obligated to pay 100%, 80% or 50% of the total fee, therefore, is inapposite.¹⁸ In every case, regardless of what percentage of the total fee is paid by Delta, the payment ease and certainty for Delta’s portion of the total fee does not vary and the amount paid by Delta always is reduced by a full 5%. The identical analysis applies, therefore, no matter what percentage of the total fee Delta is paying.¹⁹ Delta must justify 5% as a reasonable amount; it cannot justify its 5% discount by claiming that it “effectively” is a 2.8% discount.

Delta asserts that its Premier discount in the amount of 5% originated by reference to a survey conducted by the Massachusetts Dental Society (“Dental Society”) in the mid-1960’s, which gathered information from dentists relating to the timing and collectability of their receivables and the level of their bad debt experience. The study found that the average uncollectible accounts receivable for Massachusetts dental practices over a three-month period was 4%. Delta’s contention that this study provided the original basis for the 5% discount used by Premier is supported by statements made by the Middlesex District Dental Society in connection with its proposed Resolution 19-90.²⁰ To the extent that bad debt was part of the

¹⁷ Delta makes this point at page 16 of Delta’s Post-hearing Statement.

¹⁸ Ms. Leonin testified that over the last ten years the 5% discount has amounted to a discount of 2.8% of the Premier fees in aggregate. Ms. Donohue in her March 6 Affidavit refers to Delta’s “effective 2.8% discount.” These observations overlook that, although the percentage of the total fee amount that Delta pays may vary, the 5% is always applied to 100% of the portion of the total fee that Delta pays. The discount, accordingly, is always in the amount of 5% insofar as it relates to the “ease and certainty” of receiving payment from Delta.

¹⁹ The Dental Society misses the point of the statute when it argues that the only “certainty” with Premier is that a participating dentist will not be paid 100% of the submitted fee. The “ease and certainty of payment” contemplated by the statute refers only to payments that are made by Delta; not to the fees that dentists may wish to collect. Dr. Dennis’ complaint about the increase in the dollar amount of Delta co-pays (technically, patient coinsurance obligations) also is irrelevant to the ease and certainty of payment assessment under the statute. Even if true that the larger the coinsurance obligations, the longer it takes to collect them, payments made by Premier subscriber-patients play no role in the § 4 ease and certainty of payment analysis.

²⁰ This material is part of Exhibit B to Ms. Donohue’s March 6 Affidavit.

justification for a discount in the amount of 5% in the 1960's, this criterion for setting the level of discount no longer supports a 5% figure. Dr. Timothy Snail, an economist who testified on behalf of the Dental Society, testified that dental practice bad debt levels have dropped more than seven-fold, to 0.5%, according to a 2006 American Dental Association survey. This figure is dramatically lower than the testimony on which the presiding officers appeared to rely in reaching their conclusions in the *1996 Decision*, page 16.²¹

Gary Takacs, a dental practice management advisor and consultant who testified on behalf of Delta in this proceeding, stated that “an ordinary dentist is likely to have uncollectible accounts receivable of between 3% and 5% of total charges.” I found Dr. Snail’s testimony, based on an American Dental Association 2006 survey, was more persuasive than Mr. Takacs’ testimony, which Mr. Takacs stated was based on his “own experience and the available information from the extensive literature on this subject.” Mr. Takacs’ reference to a *Dental Economics* study, finding an average of 3.2% overall, but finding that a general dentist’s average bad debt in 2008 ranged from 3.1% to 5.6%, “depending on the geographical area,” was not specific enough to Massachusetts to be persuasive, even though, based on his experience, Mr. Takacs stated that Massachusetts dentists have a similar percentage of uncollectible receivables as do the dentists in other parts of the country. Mr. Takacs’ testimony was further weakened by Dr. Snail’s observation that, according to the 2008 *Dental Economics* study relied on by Mr. Takacs, only 1% of accounts receivables are written off as uncollectible by general practitioners in major metropolitan areas, large cities and medium-sized towns; and by general practitioners in all geographical areas.

The Dental Society argues that a 5% discount no longer is reasonable in a world in which dentists increasingly accept payments from their patients by credit card. Mr. Takacs testified that today the majority of dental offices in the United States accept payment by credit card. Payment by credit card is a meaningful comparison to make when evaluating the value to participating

²¹ In 1996, based on a study reported by *Dental Practice and Finance*, Gary Takacs, a dental practice management advisor and consultant who testified on behalf of Delta, stated that dental practices were writing off an average of approximately 3.8% of annual billings as bad debts.

dentists of the ease and certainty of payment by Delta.²² In both cases, a financial obligation is paid by a third party, the third party is accepted as having sufficient capital to meet the assumed payment obligation, and the third party makes payment promptly. While a dentist receives payment by means of credit card almost immediately, over 80% of claims submitted to Delta over the last several years have been processed within five business days, and over 97.5% have been processed within 15 business days.²³

Dr. Snail, an economist who spoke on behalf of the Dental Society, testified that in the 1960's, on a national basis, credit card issuers generally charged merchants a 5% fee per transaction. In 1996, Mr. Takacs testified that the cost to a dental practice for accepting major credit cards could range from less than 2% to as much as 6%. *1996 Decision*, page 8. Dr. Snail's written testimony was that credit card issuers today, on a national basis, generally charge merchants a 2-3% fee per transaction.²⁴

Four Massachusetts dentists testified about their costs connected to accepting credit cards. Dr. Milton Glicksman, President of the Dental Society and a practicing dentist in Massachusetts for more than 40 years, testified that he pays about 1.75% or 1.78% when a patient pays with a Visa or MasterCard credit card, the most frequently used cards; more when an American Express card is used. Dr. Andrea Richman, a former President of the Dental Society who has practiced dentistry for 28 years and has an office in Carlisle, testified that approximately one third of her collections are paid by credit card each month, and that she pays 1.85% in credit card fees. Dr. Charles Silvius, Secretary of the Dental Society and a practicing dentist in Massachusetts for over 30 years, with offices in Boston and Revere, testified that

²² There has been testimony in this docket about the costs to dentists of third-party financing. This approach to receiving payment, however, has aspects that are significantly different from payment by Delta; too different to provide meaningful comparison. Payment by credit card, as is true for payment by Delta, does not involve the dentist in a patient's application for a loan. In any event, I found Dr. Snail (5%) to be more persuasive than Mr. Takacs (7%) about the probable cost to a Massachusetts dentist of using third-party financing. Dr. Snail convinced me that he had more familiarity with Massachusetts conditions than did Mr. Takacs, although Dr. Snail relied upon data from only two Massachusetts dentists, Drs. Silvius and Dennis.

²³ The promptness of Delta's payments to participating dentists was underscored by the data that Ms. Donohue supplied in her March 6 Affidavit about the rarity of its payment of interest pursuant to M.G.L. c. 176E, § 4(¶2).

²⁴ Dr. Snail orally testified that at present, on a national basis, payment by credit card generally involves a discount of 1.5% to 3%.

MasterCard charges him 2.39% for transactions costing \$1.00 to \$19,999.00, plus a \$0.07 flat fee per transaction; and 1.39% for transactions costing more than \$19,999.00. Dr. William Dennis, a Shrewsbury dentist for 36 years and a Premier participating dentist since 1972, testified that his practice accepts both MasterCard and Visa, with MasterCard charges ranging from about 1.5% to 2.64%, and Visa charges ranging from 1.99% to 2.64%. Although I would hesitate to use this sample of only four dentists as an independent basis for making findings, I find that the testimony of Drs. Glicksman, Richman, Silvius and Dennis corroborates that of Dr. Snail.

Delta has taken several steps to render its claims procedures less onerous to dentists.²⁵ Although dentists may elect, at their option, to submit pre-treatment estimates, Delta does not require eligibility verifications, pre-authorizations, or fee reporting beyond the ordinary submission of claims. It has implemented technological advances and simplified its processing requirements. It accepts both electronic and paper claim submissions, and no longer requires supporting documentation for certain procedures. At present, dentists may verify eligibility by telephone, facsimile and on Delta's website, and people are available to answer dentists' questions by telephone.

Despite Delta's efforts to lessen administrative burdens, which to some extent are unavoidable for a dental insurer, I am persuaded that it is not as easy, comparatively speaking, for Premier participating dentists to be paid by Delta as it is to be paid by means of credit cards. The process of submitting a bill for services to Delta, or to any other dental insurer, adds more administrative costs to running a dental practice than does the minimum administrative burdens of accepting payment by credit card. A credit card issuer, for example, does not require a dentist to justify the therapeutic efficacy of proposed dental treatment, whereas such explanation and advocacy sometimes is required by dental insurers. The lower administrative costs associated with payments by credit card made by nonsubscriber patients and the widespread use of credit cards in today's society support a lesser discount for ease and certainty of payment by Delta at the present time. While a discount in the amount of 5% has been found to be reasonable in the past, Delta has not persuaded me that a discount specifically in the amount of 5% at present is a

²⁵ Mr. Mandel discussed the initiatives that Delta has undertaken to make it easier for dentists to interact with Delta at Tr. 84 *et seq.*

reasonable reflection of the comparative ease and certainty of payment by Delta in modern circumstances.

C. The CPI Adjustment

Delta states that on April 1, 1990, it started using a CPI as a check on increases in Premier “customary maximum allowable fees” from one periodic update to another. The CPI adjustment, however, was not addressed in the only hearing about Premier’s fee methodology since the advent of the adjustment in 1990. See *1996 Decision*.²⁶

Delta defends its use of the CPI “because it reflects an objective, broad-based inflation factor which is commonly used by businesses and consumers.” See “Post-hearing Statement of Delta Dental of Massachusetts,” filed on January 16, 2009 (“Delta’s Post-hearing Statement”), page 10. Delta rejects the Dental Society’s call for it to use the so-called “dental CPI” in its Premier methodology because using it “as a cap would be inherently inflationary because the index is driven by the fees charges by the dentists and is not a measure of their input costs.” See Delta’s Post-hearing Statement, page 10. As part of its final submissions, Delta explained that the CPI it uses “reflects the cost to an urban consumer of purchasing a basket of goods and services on a retail basis,” and that the “prices at which dental services are billed by dentists are included in the CPI under the category of medical care.” See Ms. Donohue’s March 6 Affidavit, page 2. None of these explanations justifies use of Delta’s CPI.

Delta has not justified why the cost to an urban consumer of purchasing a basket of goods and services on a retail basis constitutes a reasonable basis upon which to cap reimbursements of Premier participating dentists. Delta has not demonstrated that its CPI reflects a Massachusetts dentist’s cost of doing business. I am not persuaded that these costs are tracked or mirrored by the consumer price index that Delta employs.

In part, Delta defends its CPI adjustment because the prices charged for dental services are included in its CPI under the category of medical care. Delta, however, rejects the use of the

²⁶ Although Delta apparently was using the CPI adjustment as part of Premier’s fee methodology at the time of the hearing that resulted in the *1996 Decision*, it did not describe the adjustment in the statement it filed in that proceeding. See “Delta Dental Plan of Massachusetts’ Statement in Support of Proposed Fees for DeltaPremier Product to be Effective April 1, 1996,” pages 6-8, submitted in the present docket by the Dental Society on March 16.

“dental CPI” for its adjustment, dismissing it as merely an index of what dentists charge.²⁷ The inclusion of retail dental charges in Delta’s CPI is no justification for its use, for the same reason that Delta rejects use of the “dental CPI.” Justifying Premier’s use of its CPI because it includes dental charges for the region, furthermore, creates an intellectual anomaly. Delta already collects Massachusetts-specific information about the prices at which dental services are billed when it collects the data on which Premier’s “customary fees” are based. Unlike Delta’s CPI, the “customary fees” are based specifically on the charges submitted to Delta by Massachusetts dentists (their “usual fees”). Delta has not explained why it is reasonable to cap dental reimbursements to Massachusetts dentists by reference to a CPI that contains within it dental charges made by dentists in several states, when Massachusetts-specific data has been collected.²⁸

Ms. Donohue in her March 6 Affidavit defends Delta’s CPI adjustment as a necessary “cost-containment” measure. Even if Delta’s CPI is viewed as a means of controlling dental claims costs, Delta’s choice of index on this record is arbitrary and therefore unreasonable because it is not reflective of the costs of dental practice. It is reasonable for Delta to seek to build into its fee methodology some mechanism to control fee increases, but if it chooses to use an economic index for this purpose, such an index should be reflective of increases in costs associated with running a dental practice in Massachusetts.

Another problem with Delta’s CPI adjustment is that, if the CPI-driven nature of the April 1, 2008 periodic update is duplicated for several periodic updates *ad seriatim*, the “customary maximum allowable fee” for a procedure will lag further and further behind the amount that lies at the 90th percentile of participating dentists’ “usual fees” for that procedure. Over years of updates, the “customary” aspect of Premier’s fee methodology would depart, for the vast majority of dental procedures, further and further from the reality of the 90th percentile at which Massachusetts dentists usually are charging their nonsubscriber patients. A fee methodology with such a dramatic disconnect is inherently unreasonable.

²⁷ Ms. Leonin explained that the price index called the “dental CPI” relates to the cost to a consumer of purchasing dental goods and services for the most common dental procedures in certain urban areas.

²⁸ At page 10, note 9, of Delta’s Post-hearing Statement, Delta rejects use of the “dental CPI” in part because it “is neither state- nor region-specific.”

Delta also defends its CPI adjustment as an effective method for protecting customers, who lack the benefit of dental price transparency. Premier's fee methodology, however, is not transparent, either for subscribers or for dentists. Delta describes its most common plan design as a "100-80-50" model, covering preventive care at 100%; basic restorative care at 80%; and major restorative procedures at 50%. See note 8, *supra*. The 80% and 50% nomenclature, however, inaccurately describes the relative contributions of Delta and its subscribers. The confusion occurs because the 5% discount is applied only to the portion of the dentist's submitted fee or "profile fee" that is paid by Delta.²⁹ For dental procedures covered on what Delta refers to as a 50% basis, therefore, Delta actually pays 47.5% of the dentist's submitted fee or "profile fee," while the subscriber pays 50%.³⁰ For dental procedures covered on what Delta refers to as an 80% basis, Delta pays 76% of the dentist's submitted fee or "profile fee," while the subscriber pays 20%. Dentists may be confused by Premier's fee methodology because Delta's explanatory materials concentrate on describing the 90th percentile procedure, and provide little information about Delta's CPI adjustment, when, in fact, the CPI adjustment recently determined the "customary maximum allowable fee" for 293 out of 294 procedure codes.³¹

To control its claim costs, Delta may choose to establish a maximum allowable fee for each dental procedure code. Control of dental costs is a public benefit, potentially resulting in lower premiums, more citizens with dental insurance, and better dental health in the Commonwealth. Delta's present methodology for setting these maximum allowable amounts for Premier, however, contains flaws that make it unreasonable. This decision states no opinion about whether Premier's "profile fees" are objectively adequate reimbursement for the dental services performed; it is Delta's fee methodology for setting these amounts that this decision

²⁹ This circumstance does not arise with the BlueCrossBlueShield dental plan's 5% discount, because this discount is applied only when the plan covers a procedure 100%. See page 9, note 6 of Delta's Post-hearing Statement.

³⁰ M.G.L. c. 176E, § 4 does not require Delta to pay less than do its subscribers; just less than the average nonsubscriber patient pays.

³¹ "Methods of Reimbursement for Delta Dental Premier" (Delta Exhibit 9) states that "[i]ncreases to the customary maximum are limited by the Consumer Price Index." The lower right hand corner of the second page of Delta Exhibit 9 bears the legend "Revised: 3/2008."

finds to be unreasonable.³² Delta's assertions that disapproval of its Premier fee methodology necessarily will result in higher premiums, therefore, are unfounded.

D. Delta's Argument that Its Premier Fee Methodology Must be Reasonable Because Its Fees are Greater than the Payments Made by Some Other Dental Service Plans

Delta argues that its Premier fee methodology must be reasonable because its fees exceed the payments made by some other dental service plans that are active in Massachusetts. With respect to three of Delta's seven main competitors, however, Dr. Lawrence Wu, an economist who testified on behalf of Delta, offered no comparisons in Delta Exhibit 29 (Dr. Wu's Exhibit 2).³³ Most of Dr. Wu's comparisons with plans offered by the other four competitors, furthermore, compare provider fee payments made by Premier to provider fee payments made by plans that are approved as preferred provider plans under M.G.L. c. 176I.

Delta argues that it is appropriate to compare Premier's fees with those of preferred provider plans because they demonstrate reimbursement levels that Massachusetts dentists are willing to accept for services they perform. Delta also asserts that the comparison of Premier to preferred provider plans is appropriate because they are analogous in their basic structure and operation: (1) the insurer in both instances provides members access to a network of dentists who have agreed to participate in the network and accept a contracted fee for their services; (2) participating dentists in both instances agree to accept the contracted fee as full payment for their services, forgoing "balance billing" of patients for the difference between the contracted fee and the dentist's submitted charge; and (3) M.G.L. c. 176I preferred provider plans represent a substantial share of the Massachusetts market for dental insurance.³⁴

³² For example, this decision does not determine a reasonable charge for a periodic dental examination.

³³ Dr. Wu testified that Delta's "key competitors" in Massachusetts include BlueCrossBlueShield, Guardian Life, Metropolitan Life, Altus Dental, CIGNA Corporation, Aetna and Principal. Dr. Snail identified the same list as the "main competitors" of Delta in Massachusetts. Dr. Williams and John Brouder, a broker and consultant about medical, dental, vision and life disability benefits, also identified the same competitors.

³⁴ Dr. Wu states that M.G.L. c. 176I preferred provider plans insure approximately 58% of the Massachusetts insured population.

The Dental Society asserts that Dr. Wu's comparisons of Premier fees to those paid under preferred provider plans are not meaningful. Among other reasons, Dr. Snail explained that dentists who participate in preferred provider plans accept discounts to their dental service fees because they expect the marketing practices of such plans to bring additional patients to them, in part because their marketing practices have features that have no parallel in plans such as Premier.³⁵

If Delta had compared its Premier fees with those of all of its main competitors and made more comparisons with fees paid by plans other than preferred provider plans, its comparisons might have been more persuasive. Ultimately, however, a comparison of end results cannot in itself justify Premier's current fee methodology. This decision does not address the objective sufficiency of the amounts that Delta pays Premier participating dentists for the dental services they perform. The fee methodology itself must be reasonable and, as detailed above, the current Premier fee methodology has been found to have unreasonable aspects.

V. Conclusions

For the reasons stated in this decision, I find that the methodology employed by Delta to reimburse its Premier participating dentists is unreasonable. Practical considerations, however, dictate that Delta must be given time to develop a new Premier fee methodology and, in the interim, must be able to continue to operate. The Division does not want to disrupt Delta's day-to-day operations, create unease among its subscribers and participating dentists, or influence its competitive position vis-à-vis other providers of dental insurance in the Commonwealth, insofar as this can be avoided.

³⁵ At the 1996 hearing, Scott O'Gorman, Senior Vice President of Delta, testified that "DeltaPreferred [a Delta preferred provider plan] utilizes a limited network of providers who agree to accept a lower table of allowances which, with Delta's implemented increase of six percent effective April 1, 1996, approximates a 25 percent reduction from the usual and customary fees paid under DeltaPremier." According to Dr. Snail, Delta's website currently reports discounts off dental fees of at least 10% for Premier, but of up to 25% for Delta preferred provider plans.

VI. Orders

No later than 90 days from the filing date of this decision, Delta shall submit for the Division's approval a new fee methodology for its Premier product, together with a plan for implementing it.³⁶

Delta's existing contracts with Premier participating dentists and Premier subscriber accounts shall continue in force despite the filing of this decision, as shall Premier's current fee methodology. Delta, furthermore, may continue to renew or enter into new Premier contracts with subscribers and dentists on the same terms as it does at present until its new Premier fee methodology is approved.

This docket may be reopened for further orders, as appropriate.

Filed: April 14, 2009

Stephen M. Sumner, Esq.
Presiding Officer

Affirmed:

Date: April 14, 2009

Nonnie S. Burnes
Commissioner of Insurance

³⁶ Ms. Donohue in her March 6 Affidavit predicts that the process of creating and gaining approval of a new fee methodology "would take well in excess of one year." This Decision and Order sets a deadline by which Delta must submit a new Premier fee methodology for the Division's review; not a date by which Division approval must be obtained.

Appendix A

Michael P. Tsotsis, President of Benefit Development Group; Bill Higgins, Vice President of Business Development of Thorbahn Associates; Allen Hymovitz, Benefits and HRIS Manager of The Charles Stark Draper Laboratory; and John P. Foran, President of John P. Foran Insurance Agency, Inc., submitted written comments prior to the public comment portion of the hearing. Kathryn Shanley spoke at the public comment portion of the hearing on behalf of Altus Dental Insurance Company.

Fay Donohue, President and Chief Executive Officer; Elizabeth Leonin, Director of Underwriting; Dr. Doyle Williams, Chief Dental Officer; Guy Mandel, Director of Operations; and Wendy Karle, Vice President of Sales and Professional Relations, testified at the hearing on behalf of Delta: Gary Takacs, a dental practice management advisor and consultant; Dr. Lawrence Wu, Ph.D., an economist and Senior Vice President at National Economic Research Associates; John Brouder, a partner at Boston Benefit Partners, LLC; and Susan Fournier, Executive Director of the Massachusetts Public Employees Fund; also testified on behalf of Delta. Delta was represented by Daniel T. Roble, Esq., Jane E. Willis, Esq., and Anne E. Johnson, Esq.

The Dental Society provided oral testimony from Dr. William Dennis, Dr. Milton Glicksman; Dr. Andrea Richman and Dr. Charles Silvius, and written testimony from Dr. John P. Fisher, all Massachusetts dentists who are DeltaPremier participating dentists. Timothy S. Snail, Ph.D., an economist and principal at CRA International, also testified on behalf of the Dental Society. The Dental Society was represented by Vincent F. O'Rourke, Jr., Esq., John S. Ziemba, Esq., and Daniel R. Judson, Esq.