From:	Paul Klein
To:	Insurance Regulation
Subject:	Regarding Regulation Workshop: R134-24 Dental Loss Ratio
Date:	Wednesday, January 22, 2025 10:09:43 AM
Attachments:	ADA Resolution 306_CDBP2024May.pdf

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Good morning, I am writing to submit the American Dental Association's official policy on calculating dental loss ratio for the workshop's participants to consider. Please see attached.

Thank you,

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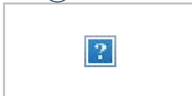

Resolution No. 306 New

Report: N/A Date Submitted: May 2024

Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice, Science, Health and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

1 AMENDMENT OF POLICY: MEDICAL (DENTAL) LOSS RATIO

2 **Background:** The Council on Dental Benefit Programs has reviewed the following Association policy
3 addressing dental plan loss ratios titled Medical (Dental) Loss Ratio (*Trans.*2015:244; 2019:262).
4 During the review process, the Council sought feedback from members through an online comment form.
5 The Council received a total of 116 comments. Commenters suggested that the Council consider the
6 following when revising the policy:

7 • Include specific definitions
8 • Include a specific MLR percentage
9 • Require robust reporting requirements
10 • Address deduction of expenses from premiums as "community benefit dollars" such as monies
11 funneled into foundations as charitable contributions

12 Based on this input, the Council discussed several issues when amending the current policy. The
13 sections below provide a summary of Council discussions and justification for the proposed policy
14 position.

15 I. **Specific Definitions**: In trying to define the numerator and denominator the Council considered
16 similar definitions adopted by states that currently have some form of MLR legislation in place.
17 The table below provides a summary of existing definitions.

State	Numerator	Denominator
Arizona	(A) the numerator is the sum of all of the following: (i) the adjusted incurred annual dental claims in this state. (ii) the amount spent by a dental insurer on activities that improve the quality of dental care but does not include expenses for advertising, promotions or donations to charitable foundations. (iii) the amount of claims identified through fraud reduction efforts.	(b) the denominator is the sum of the annual dental insurance premiums earned in this state, excluding: (i) the annual incurred federal and state taxes, licensing fees and regulatory fees on dental premiums in this state. (ii) the annual federal income taxes attributed to the dental line of business for the reporting year.

California	(b) Numerator. The numerator of a health plan or health insurer's MLR for a MLR reporting year must be the health plan or health insurer's incurred claims	(c) Denominator. The denominator of a health plan or health insurer's MLR must equal a health plan or health insurer's premium revenue, excluding a health plan or health insurer's Federal and State taxes and licensing and regulatory fees.
Colorado *Regulation*	The numerator is the sum of: a. The amount incurred for clinical dental services provided to enrollees; b. The amount incurred on activities that improve dental care quality; and c. The amount of claims payments identified through fraud reduction efforts, not to exceed the amount spent on fraud reduction efforts	The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures, and any other payments required by federal law. Nonprofit community benefit expenditures are community benefit expenditures made by entities that are exempt from federal income tax. These nonprofit community benefit expenditures included in the denominator must be limited to the highest of either: a. Three percent of earned premium; or b. The highest premium tax rate in Colorado, multiplied by the carrier's earned premium in the applicable Colorado market.
Maine *Regulation*	The numerator is the sum of: (1) The amount expended for clinical dental services provided to enrollees; (2) The amount expended on activities that improve dental care quality; and (3) The amount of claims payments identified as having been avoided or recaptured through fraud reduction efforts; and	The denominator is the total amount of premium revenue, excluding federal and state taxes and licensing and regulatory fees paid. For nonprofit carriers that are exempt from Maine taxes, the pro rata share of the carrier's community benefit expenditures may be excluded, in the same proportion that the carrier's premium for fully and partially credible Maine dental plans bears to the carrier's total premium for all lines of business, up to a maximum of two percent of the gross premium, before exclusions, for fully and partially credible Maine dental plans.
Washington	dental loss ratio that is computed by dividing the total amount of dental payments by…	…the total amount of dental revenues.

Massachusetts (*final regulation*)	Incurred Claims during a specified period for covered dental services plus Qualified Quality Improvement Activity expenses, which is then divided by.... Additional Definitions [Incurred Claims. Dental Services costs, including eligible Fraud, Waste, and Abuse Recoveries (The amount of claims payments recovered through fraud, waste, and abuse reduction efforts, not to exceed the amount of fraud, waste, and abuse reduction expenses.), incurred in a reporting period by a Dental Benefit Plan to be paid to Dental Providers or covered persons for activities by a Dental Provider. Qualified Quality Improvement Activity: An activity designed to improve dental quality that is performed equitably, including activities performed by or through a provider that are primarily designed to improve dental outcomes, including, but not limited to, activities with a likelihood of reducing disparities among specified populations or which promote and enhance dental wellness. A QIA is directed to individual patients or incurred for the benefit of specified segments of patients, increases the likelihood of desired clinical outcomes that are capable of being objectively measured and/or which produce verifiable results, requires expertise, increases wellness and promotes health activities, and is directed toward individual Members of a Carrier's plans or segments of Members, as well as populations other than Members (as long as no additional costs are incurred for the non-Members, and as long as the activity can be supported by evidence-based medicine, best clinical practices, or criteria issued by professional associations ...]	.....earned dental premiums reduced by Federal and State Taxes, Assessments, and Licensing or Regulatory Fees.
Nevada *Statute*	Average ratio of losses to premiums collected...	

New Mexico *Regulation*	(1) Numerator. The numerator is equal to the incurred claims for the loss ratio reporting year.	(2) Denominator. The denominator is the earned premiums for the loss ratio reporting year.

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2 Based on these existing definitions, the Council decided to define the numerator and denominator as
3 follows:
4 • The numerator is the sum of the amount paid for clinical dental services provided to enrollees and
5 the amount paid to providers on activities that improve oral health for plan enrollees.
6 • The denominator is the total amount of premium revenue, federal and state taxes, licensing and
7 regulatory fees paid, and any other payments required by federal law

8 The Council discussed including more specificity around terms used within the numerator and
9 denominator such as "amount paid for clinical dental services", "nonprofit community expenditures", etc.,
10 within ADA policy. However, given the complexity of such definitions, the Council chose not to include
11 these details within the policy. The Council has provided details, as guidance to assist states enacting
12 MLR legislation. The Council encourages state dental associations engaged in advocating for MLR to pay
13 close attention to accounting for "nonprofit community expenditures" and "fraud, waste, & abuse", etc. If
14 the proposed amendments to the current policy are adopted by the 2024 House of Delegates, the Council
15 will include these definitions noted in Appendix 1 within the ADA Glossary of Dental Administrative
16 Terms.

17 II. **Specific MLR percentage**: The Council identified 3 states with a specific MLR percentage.

18 • New Mexico: 65%
19 • Nevada: 75%
20 • Massachusetts: 83%

21 The Council also noted that the Centers for Medicare & Medicaid Services (CMS) stipulates an 85% MLR
22 for Medicaid managed care, even for dental plans that manage the dental benefit in Medicaid (referred to
23 as "PAHP" or Prepaid Ambulatory Health Plan) separate from the medical benefits managed by a
24 managed care organization (i.e., MCO).

25 Other than these existing standards, the Council was unable to identify a data-based methodology to
26 establish a numerical benchmark for MLR across the nation. Based on states that currently have a
27 reporting requirement (e.g., California), the Council noted that large group plans such as Delta Dental of
28 California report an MLR as high as 88%. MLR also varies by large group and small/individual market
29 segments. Based on these experiences the Council continues to strongly believe that:

30 • MLR should be state specific, and a national number should not be established
31 • Existing average MLR by market segment can be a useful guide when first establishing an
32 MLR for plans in the state
33 • Ultimately states should aspire to achieve a loss ratio of 85% for large group plans and 80%
34 for small/individual groups over time

35 III. **Robust Reporting Requirements**: The Council notes that "MLR reports" are not simply a single
36 number. In fact, an MLR report is a detailed reporting of several line items across all the plans
37 administered by the carrier. The standard used to report MLR across the health insurance market
38 is the MLR Annual Reporting Form (CMS-10418). A similar form was adopted for reporting dental
39 loss ratio for plans in California. Publicly reported DLR for California plans can be found at the
40 California Department of Insurance and the Department of Managed Care. The Council
41 supported the use of the existing MLR standard forms for robust reporting.

IV. **Charitable Contributions:** The Council noted that the traditional definitions of MLR have allowed exclusion of funds used for "charitable contributions" from the premium revenue before calculating the MLR. As non-profits, several dental carriers purport to support a public health mission. The Council strongly believes that non-for-profit registered dental carriers can continue to meet their non-profit mission using funding separate from premiums paid by specific employer groups for the betterment of their specific employee populations. Directing premium revenue away from these employees is in fact inappropriate for these employer/employee groups. For these reasons the Council believes that any expenditures for community benefit should not be included in the numerator OR deducted from denominator.

V. **Removal of reference to "ERISA plans"**: The 2019 version of the MLR policy adopted by the House of Delegates required adoption of MLR for "ERISA benefit plans". The Council wishes to note that the concept of MLR does not apply to self-funded plans. As such, self-funded plans are funded by the employer, i.e., the claims are paid directly by the employer and a third party is used only to administer the plan. The financial "risk" from any unanticipated claims experience affects the employer and not the third-party administrator. In such instances the administrator is not paid a premium and instead earns a service fee for services performed such as claims processing, call center management, network administration, etc. Given that there is no "premium" paid to the carrier, a loss ratio does not apply.

Based on these discussions, the Council proposes the following resolution.

Resolution

306. Resolved, that the policy titled Medical (Dental) Loss Ratio (*Trans.*2015:244; 2019:262) be amended as follows (additions underscored; deletions ~~stricken~~).

Medical (Dental) Loss Ratio

Resolved, that the ADA supports the concept of a "Medical Loss Ratio" for dental plans defined as the proportion of premium revenues that is spent on clinical services, specifically:

(A) The numerator is the sum of (1) the amount paid for clinical dental services provided to enrollees and (2) the amount paid to providers on activities that improve oral health through clinical services for plan enrollees.

(B) The denominator is the total amount of premium revenue, excluding only (1) federal and state taxes, (2) licensing and regulatory fees paid, and (3) any other payments required by federal law.

and be it further

Resolved, that states pursuing MLR, refer to the definitions of each of the amounts referenced in the numerator and denominator within the ADA's Glossary of Dental Administrative Terms maintained by the ADA Council on Dental Benefit Programs (CDBP), and be it further

Resolved, that dental plans, both for profit and nonprofit should be required to make information available to the general public and to publicize in their marketing materials to plan purchasers and in written communications to their beneficiaries the percentage of premiums that fund treatment and the percentage of premiums that go to administrative costs, promotion, marketing and profit, or in the case of nonprofit entities, reserves, and be it further

Resolved, that the ADA support legislative efforts to require dental benefit plans to file a comprehensive MLR report annually, which contains the same information required in the 2013

1 federal MLR Annual Reporting Form (CMS-10418) along with number of enrollees, the plan cost-
2 sharing and deductible amounts, the annual maximum coverage limit, and the number of
3 enrollees who meet or exceed the annual coverage limit and to establish a specific loss ratio for
4 dental plans in each state, ~~and ERISA benefit plans.~~ and be it further

5 **Resolved**, that a "specific loss ratio" be calculated by each state as the average dental loss ratio
6 for each market segment (large group and small/individual groups as defined within the state). If
7 the average loss ratio is less than 85% for large group plans and 83% for small/individual groups,
8 then states should aspire to establish a mechanism to have MLR improved to at least this
9 benchmark over time. For those carriers reporting MLR above 85%, such carriers should be
10 required to maintain operations at that level, and be it further

11 **Resolved**, that when a carrier fails to meet the MLR, the carrier be required to issue rebates to
12 plan purchasers, and be it further

13 **Resolved**, that instituting an MLR should not result in premium rate increases in excess of the
14 percentage increase of the latest dental services Consumer Price Index as reported through the
15 US Bureau of Labor Statistics.

16 **BOARD RECOMMENDATION: Vote Yes.**

17 **BOARD VOTE: UNANIMOUS**

Appendix 1

GUIDANCE ON DEFINITION OF TERMS

The Council suggests that the following serve as guidance for definitions for terms that states could consider when instituting a loss ratio for dental plans. These definitions were sourced from:

Numerator definitions:

- "Amount paid for clinical dental services" must only include direct claims paid to providers, including under capitation contracts, for clinical services covered by the plan. Amount should not include:

    1. funds withheld from providers for any reason
    2. over payments recovered from providers
    3. any cost-sharing amount paid by the plan enrollee
    4. adjustments recouped pursuant to coordination of benefit policies
    5. payments recovered through fraud reduction efforts
    6. share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans issued by the same carrier

- "Amount spent on oral health improvement activities" must only include activities that are:

    1. directed toward individual enrollees, i.e., plan participants or incurred for the benefit of specified segments of plan enrollees to improve access and outcomes
    2. based on clearly defined, objectively measurable, evidence-based criteria issued by the ADA or nationally recognized healthcare quality organizations

- Expenditures and activities that must not be included are those that:

    1. are designed primarily to control or contain costs
    2. are expenditures towards community benefit or persons not enrolled in the plan
    3. were paid for with grant money or other funding separate from premium revenue
    4. can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services

Denominator definitions:

- "Amount of premium revenue" means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan. Amounts should include any state or federal subsidy.

Overhead administrative cost expenditures that should not be included in the numerator or deducted from the denominator include expenditures related to:

- "Nonprofit community expenditures" means expenditures for activities or programs expended by the carrier for enhancing public health for people who are not beneficiaries of the plan. This includes activities that:

    1. are available broadly to the public, e.g., activities supporting water fluoridation
    2. reduce geographic, financial, or cultural barriers to accessing health services or

1 3. advance health care knowledge through education or research that benefits the public

2 • network development, secondary network savings, administrative fees, claims processing, and
3 utilization management, fraud prevention activities, provider credentialing or marketing expenses
4 regardless of whether these activities are performed by the carrier or outsourced to a third-party
5 vendor
6 • providers such as consultants, for professional or administrative services that do not represent
7 compensation or reimbursement for covered services provided to an enrollee
8 • establishing or maintaining a claims adjudication system, including costs directly related to
9 upgrades in health information technology that are designed primarily or solely to improve claims
10 payment capabilities or to meet regulatory requirements for processing claims
11 • developing and executing provider contracts and fees associated with establishing or managing a
12 provider network, including fees paid to vendors
13 • stop-loss or re-insurance costs
14 • direct sales salaries, workforce salaries and benefits
15 • agents and brokers fees and commissions
16 • General and administrative expenses