BUREAU OF INSURANCE
BASIS STATEMENT AND SUMMARY OF COMMENTS
02-031 C.M.R. CHAPTER 835
DENTAL INSURANCE PLAN LOSS RATIO REPORTING

Acting Superintendent of Insurance Timothy N. Schott hereby adopts rule Chapter 835, "Dental Insurance Plan Loss Ratio Reporting," pursuant to 24-A M.R.S. §§ 212 and 4319-B. The purpose of the proposed rule is to establish standards for calculating average loss ratios for plans providing dental care services, reporting dental loss ratios to the Superintendent, determining dental plan credibility, and to establish a process to determine outlier dental plans.

On March 17, 2023, the Bureau published a Notice of Rulemaking setting the public hearing at 9:00 a.m. on April 12, 2023 and closing the comment period at 4:30 p.m. on April 24, 2023. On March 17, 2023, the Bureau posted the proposed rule to its website, distributed it to subscribers to the Bureau's e-mail subscription service, and filed a Rule-Making Fact Sheet with the Maine Secretary of State, published in the State Rulemaking Register on March 22, 2023, and with the Executive Director of the Legislative Council.

The public hearing took place as scheduled by videoconference. The rule is hereby adopted as proposed, subject to the changes discussed below in response to the comments and a few non-substantive editorial corrections.

Comments

The following persons commented at the hearing:

Jay Nutting, Maine Street Solutions
on behalf of National Association of Dental Plans (NADP),
America's Health Insurance Plans (AHIP), and
American Council of Life Insurers (ACLI)

Brian Duffy
Vice President and General Counsel
Northeast Delta Dental

Kristine Ossenfort, Esq.
Senior Government Relations Director
Anthem Health Plans of Maine, Inc. (Anthem)

Mr. Duffy and Ms. Ossenfort also submitted timely written comments, as did:

Bernard J. LaPine
Director, Regulatory and Legislative Affairs
United Concordia Insurance Company

Writing jointly, Owen Urech for NADP,
Amanda Herrington for AHIP
Cindy Goff for ACLI, and
Dan Demeritt for Maine Association of Health Plans (MeAHP)

Summary of Comments and Bureau of Insurance Responses

A. Section 4(1), "Administrative cost expenditures" – payroll: NADP, AHIP, ACLI, and MeAHP wrote to say the Affordable Care Act (ACA) allows qualified health plans to include salaries of personnel whose activities are tied directly to quality improvement. They recommended revising the definition of administrative cost expenditures to exclude mention of payroll expense.

Bureau Response:

The proposal to remove payroll from the definition of administrative cost expenditures is overbroad, as not all payroll is related to activities that are tied to quality improvement. Instead, we added a new Section 5(2)(D)(7) as follows:

> Payroll, except for positions dedicated to activities that improve oral and overall health and the pro rata share of payroll for positions substantially involved in such activities;

This clarifies that payroll directly related to quality improvement activities may be recognized as a quality improvement expense. We also revised the definition of administrative cost expenditures as follows to clarify that it does not include expenses that would meet the general definition but are specifically classified in some other category: for example, quality improvement payroll, or community benefit charitable expenses in lieu of taxes.

> "Administrative cost expenditures" means a carrier's financial administrative, marketing and sales, commission, distribution, claims operation, utilization review, network operations, charitable, and payroll expenses, but does not include expenses specifically recognized under this rule as expenses for activities that improve dental care quality or as community benefit expenses.

B. Section 4(1), "Administrative cost expenditures" – sales commissions: United Concordia requested that sales commissions be removed from the definition of administrative cost expenditures, asserting that they are not a part of premium and are a separate payment by the group policyholder directly to the broker.

Bureau Response:

The classification of sales commissions as administrative cost expenditures is adopted as proposed. The practice of excluding commissions from premium is illegal in Maine. With narrow exceptions that are not relevant here, 24-A M.R.S. §§ 2174 and 2403 define premium to include the entire cost of coverage and prohibit charging add-on fees. Although there is a further exception at 24-A M.R.S. § 2412-A permitting fee-based compensation in lieu of commissions for "large commercial risks," those alternative arrangements are only permitted for property and casualty insurance, not for medical or dental insurance.

C. Section 5(1) Activities That Improve Dental Care Quality: All the commentors were concerned with the proposed language stating that carriers "shall" implement such activities. They felt this was beyond the scope of the statute, which directs the Bureau of Insurance to "define" activities that improve dental care quality rather than require

carriers to implement such activities or programs. They requested a change of "shall" to "may" in Section 5(1).

Bureau Response:

The Bureau agrees that "shall" is inappropriate because quality improvement activities are not mandatory. Furthermore, as the comments also noted, the purpose of this section is not to regulate the underlying activities, but rather to address their impact on the dental loss ratio, so granting permission to undertake such activities is likewise out of scope. Accordingly, the Bureau has revised the introduction to Section 5(1) as follows:

> A carrier that offers a dental plan shall ~~implement, maintain, and update in light of evidence-based developments in treatment,~~ receive credit under Subparagraph 6(1)(A)(2) for implementing and maintaining activities that improve dental care quality, and updating them in light of evidence-based developments in treatment. ~~These~~ To qualify for recognition as activities that improve dental care quality, these activities must:

D. Section 5(1)(A), criteria for quality improvement: Anthem suggested the paragraph be amended to read as follows: "Improve oral and overall health and advance oral health quality, including increasing the likelihood of desired outcomes compared to a baseline; reducing dental disparities among specified populations; and improving patient safety, reducing medical errors, or lowering infection in ways that are capable of being objectively measured and of producing verifiable results;"

Bureau Response: The Bureau has revised Section 5(1)(A) as suggested.

E. Section 5(1)(C), evidence-based best practices: Anthem suggested deleting this paragraph, stating that it is too restrictive because a great deal of the research and innovation in the dental space is being tested and created by payers themselves, and will not be adopted as a "best practice" until after the programs have been tested by dental carriers.

Bureau Response: The language of this paragraph is taken directly from the definitional standard for activities that improve health care quality in the federal loss ratio regulation, at 45 CFR § 158.150(b)(1)(iv). Therefore, rather than deleting this paragraph, the Bureau has revised it to state that qualifying expenses must:

> ~~Are~~ Be grounded in the implementation, development, or improvement of evidence-based dental care, widely accepted best clinical practice, or criteria issued by recognized professional dental associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

F. Section 5(1), information technology expenses: Anthem requested a new paragraph clarifying that quality improvement activities include information technology to support effective case management, care coordination, chronic disease management, medication and care compliance, and other important oral and overall health initiatives.

Bureau Response:

We agree with the substance of Anthem's comment, but it is unnecessary to revise the rule to address it. As Anthem observes, these are already recognized as qualifying activities, and nothing in the rule would call that status into question. The only exclusion for information technology expenses, as discussed below, is for "upgrades in information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims." Section 5 is not intended to provide a comprehensive list of all qualifying activities, and any attempt to do so would risk the unintended consequence of implicitly disqualifying activities that are not expressly mentioned.

G. Section 5(2)(A) Exclusion for activities attributable for other lines of business. Anthem recommended that this section be deleted. This definition doesn't recognize the relationship between overall health and oral health, and would prohibit carriers from including claims in which dental is intertwined; i.e. diabetes can lead to periodontitis, pregnancy can cause periodontal disease in expectant mothers, etc.

Bureau Response: The Bureau agrees that these expenses can promote dental quality, but the reason for the exclusion is to avoid double-counting and misattribution of expenses. Section 5 (2)(A) is consistent with the federal exclusion at 45 CFR § 158.150(c)(2), and is therefore adopted as proposed.

H. Section 5(2)(D)(2) Exclusion for claims adjudication expenses. Anthem stated that because updates in health information technology qualify as a credit towards the MLR under the ACA, the provision designating claims adjudication as an administrative expense should be revised to delete the phrase "including upgrades in information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims";

Bureau Response: Section 5(2)(D)(2) is adopted as proposed. As noted in Anthem's earlier comments, information technology expenses are not unconditionally recognized as quality improvement expenses. If the primary purpose of the expense is the improvement of health care quality, it could qualify as a quality improvement expense if the other standards are satisfied. If the primary or sole purpose is claims processing, it is an administrative expense.

I. Section 5(2)(D)(6), provider credentialing expenses: Anthem stated that provider credentialing is designated as a healthcare improvement activity in the federal MLR calculation under the ACA. Therefore, they suggested striking subparagraph 6.

Bureau Response: Anthem's statement is unsupported by any citation and appears to be erroneous. 45 CFR § 158.150(c)(10) expressly lists "provider credentialing" as one of the activities that "must not be included in quality improving activities."

J. Section 5(2)(D)(7), payroll: As noted earlier, the classification of payroll as an administrative expense was revised, in response to the comment by NADP, AHIP, ACLI, and MeAHP, to distinguish between payroll in general and payroll specifically related to quality improvement. This new subparagraph was added to codify that distinction:

> (7) Payroll, except for positions dedicated to activities that improve oral and overall health and the pro rata share of payroll for positions substantially involved in such activities;

K. Section 5(2)(D)(8 and 9), marketing and enrollee incentives: Anthem suggested amending these paragraphs (formerly numbered as 7 and 8) to provide carriers with more flexibility by recognizing marketing expenses and enrollee or employee incentives as quality improvement expenses if they are used in the promotion of activities that improve oral and overall health.

Bureau Response: Although quality improvement activities might be useful to publicize for marketing purposes, that does not make marketing itself a quality improvement activity. Therefore, Subparagraph (8) is adopted as proposed. On the other hand, enrollee incentives could be used to improve health care quality, so the Bureau accepts the suggested revision to Subparagraph (9), which as revised reads as follows:

> (~~8~~ 9) Calculating and administering individual enrollee or employee incentives~~;~~ unless used in the promotion of activities that improve oral and overall health.

L. Section 6(1)(B), exclusion of taxes and fees from premium: NADP, ACLI, AHIP and MeAHP requested amending this section to allow a carrier to deduct community benefit expenditures, as defined at 45 CFR § 158.162(c), up to the amount of any state taxes, if a carrier is not-for-profit and does not pay state taxes. This amendment would level the playing field in calculating loss ratios between for-profit and tax-exempt carriers.

Bureau Response:

The Bureau accepts the suggested amendment and will permit tax-exempt carriers to deduct the pro rata share of their community benefit expenditures from premium, up to the taxes that would have been paid if the premium used in the loss ratio denominator had been subject to Maine's two percent premium tax. As revised, this paragraph reads as follows:

> 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.

M. Section 6(3), implementation date: NADP, ACLI, AHIP, and MeAHP requested that the implementation for the proposed rule of July 31, 2023 would cause significant difficulties for dental plans in Maine to provide valuable data and comply with these important requirements and requested a delay until July 31, 2024.

Bureau Response:

The Bureau rejects this request. The controlling statute, 24-A M.R.S. § 4319-B(6)(C), requires the carrier's initial report to be filed no later than July 31, 2023. Reporting instructions are currently available on the Bureau website to assist carriers with the process.

N. Reporting Template – national data: United Concordia objected to the reporting instructions which call for the use of national data for market segments with 75,000 or fewer covered lives, asserting that 24-A M.R.S. § 4319-B(2) makes the Maine dental loss ratio calculation applicable only to plans delivered and issued in Maine. They observe that different states have different standards for reporting and data collection.

Bureau Response

The reporting instructions are not part of the proposed rule and will be revised to conform to the rule. The use of national data is not inconsistent with the calculation of a state-specific loss ratio if it is simply used as a tool to enhance the accuracy of calculations based on partially credible state experience. It is a matter of actuarial judgment whether national data is relevant in a particular case, and Section 6(2) as adopted makes the use of national data permissive rather than mandatory and calls for giving appropriate weight, on a case-by-case basis, to Maine and national experience.

O. Reporting Template – claim run-out period: United Concordia suggested defining a claim run-out period for purposes of loss ratio reporting, similar to what is permitted under the ACA, and proposed that a three-month period following the end of the calendar year would be sufficient. They stated that this would promote consistency in reporting and ensure a level playing field when comparing the plan loss ratios, and that the Bureau could also consider a run-out period for premium.

Bureau Response

The three-month runout period is standard practice and is consistent with the rule as proposed. The reporting instructions will be revised to clarify this point.