DELTA DENTAL

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April 11, 2024

The Honorable Joseph J. Solomon, Jr.
Chairman, House Corporations Committee
Rhode Island State House
Providence, RI 02903

Re: Opposition to House Bill – H 7082

Dear Chairman Solomon:

On behalf of Delta Dental of Rhode Island, I am writing in opposition to the proposed legislation H 7082, which would impose a medical loss ratio of eighty-five percent for dental benefit plans.

If this bill is passed in its current form, it will result in a significant increase in premiums and disrupt the balance of access and affordability of dental care for the residents of Rhode Island. In the following pages, we will provide a detailed explanation of our concerns regarding the legislation and its potential unintended consequences, including:

- The negative impacts of the Massachusetts ballot initiative establishing an 83% dental loss ratio are just beginning to come to light.
    - Due to the complexity and stakeholder impacts, the regulations were significantly delayed and were just released, despite a mandated January 1, 2024 start date.
    - Even ahead of its implementation, more than six carriers have announced plans to stop offering coverage to individuals and small businesses in the state with more expected to follow.
    - Per a study conducted by Milliman, Inc., an actuarial consultant, this legislation is expected to lead to:
        - 38% increase in premiums
        - Higher out-of-pocket expenses for patients
        - Fewer affordable plan options
- Dental Loss Ratios should not be arbitrarily set through legislation, rather they should be determined by an insurance expert, such as the Office of the Health Insurance Commissioner.
    - The National Council of Insurance Legislators (NCOIL) has developed model legislation to this effect, which is the most prudent path to protect all stakeholders, including businesses, residents, providers, and carriers.
    - The Office of the Health Insurance Commissioner (OHIC) recently weighed in on this issue in the senate companion bill and stated in a letter of concern that, "to avoid potential substantial increases in dental premiums, OHIC would favor a data-driven approach."
    - States with legislation addressing medical loss ratios for dental plans have overwhelmingly opted for reporting measures over setting an arbitrary loss ratio.

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- Medical insurance is different than dental insurance—with premiums that can be as much as 40 times higher, despite having the same operational and regulatory requirements.
    - For example, a dental carrier has only $2.60 compared to a medical carrier's $100 to conduct the same tasks.
- Our ability to support initiatives focused on oral health workforce development and access to care will be eliminated by the passage of this legislation.
- This bill does not address the access to care concerns for the state's Medicaid population.

Delta Dental of Rhode Island is **not** opposed to minimum dental loss ratios. However, there are two fundamental considerations that go into determining whether a particular proposed loss ratio makes economic sense. Respectfully, under both considerations H 7082– *as presently drafted*, and with the proposed dental loss ratio as high as 85% - does *not* make economic sense as applied to dental insurance.

The two considerations are as follows:

(1) "High End" Minimal Loss Ratios Sometimes Applicable To <u>Medical</u> Insurance Plans – Such As The 85% Proposed By H 7082 – Are Infeasible As Applied To <u>Dental</u> Insurance"

The economics of dental plans as compared to medical plans could not be more different in every way, particularly the level of genuine administrative costs incurred per member to run the business in relation to the premiums charged. They are much higher for dental insurance plans than they are for medical insurance plans. While an 85% ratio might be feasible for medical/surgical plans it is not feasible for dental plans.

Premiums for *medical* plans are *at least 15 times – and up to 40 times* – what *dental* premiums are. By way of example, as an employer we pay a premium to our *medical* insurance carrier of $2,555.97 per employee per month family coverage. The comparative premium per employee per month for family *dental* coverage is only $101.44 – 25 times less. Even a high deductible *medical* plan would be about $1,800 per employee per month – 18 times the dental premium.

Conservatively using an $1,800 monthly premium per employee, and applying a minimum loss ratio at 85% as proposed in H 7082, would result in the following:

- The monthly *dental* premium @ $101 equals an annual cost of $1,212

- Comparatively, the *medical* premium @ $1,800 equals an annual cost of $21,600

- With the 85% minimum required dental loss ratio in H 7082 the *dental* plan has $182 per covered employee to perform its administrative duties and run the business.

- Comparatively, with an 85% minimum required loss ratio, the *medical* plan has $3,240 per covered employee to perform its administrative duties and run the business.

- Yet the *dental* plan is still subject to most of the same rules and regulations as the *medical* plan. It must pay the same wages for customer service representatives, enrollment specialists, claims

analysists, underwriters, accountants, professional relations specialists, and quality assurance and fraud detection personnel, etc., as well as the same costs per employee to outside vendors to print payment checks to dentists, explanations of benefits (EOB's) to members, and other pertinent or legally required communications.

- The extraordinary difference and hardship that a minimum loss ratio as high as 85% makes for dental coverage as opposed to medical coverage is even more profound when one considers that medical insurance claims payment costs paid to providers are astronomically higher than dental insurance claims costs. Dental plans do not cover hospitalizations or catastrophic claims, and usually involve annual maximum benefits of a few thousand dollars or less. Inasmuch as loss ratios are calculated by dividing total claims payment expenses by administrative expenses, minimum loss ratios as high as 85% are comparatively much more difficult – indeed infeasible – for dental plans to meet without other substantial adjustments to the formula, something described more fully below. No such adjustments are provided for in H 7082.

For all these reasons, State legislatures thoughtfully considering minimum loss ratios for dental plans have stayed away from the "high end of the scale" (*i.e.*, 80% plus) minimum loss ratios often imposed on *medical* plans. New Mexico, for example, the only legislature that has considered and passed a minimum dental loss ratio statute ranging as low as 65% (for vision plans it was 55% last year), a stark contrast to the 85% proposed in H 7082. To our knowledge, no other minimum dental loss ratio has ever been established that high - anywhere. Other proposals currently in play before several state legislatures feature minimum dental loss ratios considerably lower than H 7082.

Most States have wisely proceeded cautiously into this complex territory, preferring to enact dental loss ratio **reporting** requirements first to garner the statistical and actuarial experience necessary for their insurance regulators to test and understand the appropriate levels for possible future dental plan loss ratio minimums without blindly imposing historic "medical" loss ratio calculations. Maine and New Hampshire are in this category, and we understand that Connecticut is tracking in that direction as well.

The National Council of Insurance Legislators (NCOIL) recently adopted the NCOIL Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act which requires dental plans to report DLR information to the insurance commissioner, who would be authorized to take enforcement actions against any dental plans considered "outliers" to the market segment's average DLR. This method for establishing DLRs is jointly supported by both the American Dental Association and the National Association of Dental Plans.

Notably, a recent detailed article describing the different positions being taken on whether medical insurance and dental insurance should be treated very differently for loss ratio purposes observed that, "Even the ADA [American Dental Association] concedes that dental insurance belongs to a separate category." ("Insurance Newsnet" 2022; D. Bailey).

(2) H 7082 Would Unfairly And Prohibitively Include As "Administrative Expenses" (For Purposes Of The Dental Loss Ratio Calculation) Items that Do Not Belong In that Category)

The prohibitive effects of H 7082's inclusion of a "highest end" (*i.e.*, 85%) "medical" minimum loss ratio that is infeasible for dental plans is exacerbated by the bill's inexplicable inclusion of certain expenses as "administrative expenses" that are not "administrative expenses" at all. To our knowledge no minimum

loss ratios have ever been established at that high end of scale that have not involved a litany of expenses being excluded from the ratio calculation methodology.

Chief among these are federal and state taxes. Notably, when the federal Patient Protection and Affordable Care Act (the "ACA") was enacted, it required the National Association of Insurance Commissioners ("NAIC") to establish uniform definitions and standardized methodologies for calculating loss ratios. Those federal standards exclude from administrative expenses federal and state taxes, as they are completely out of the control of the carrier and cannot be avoided no matter how cost conservative and efficient the carrier is. Notably, Federal and State taxes are already duly excluded from administrative expenses in the annual loss ratio reporting that Delta Dental is already required to file with the Office of Health Insurance Commissioner ("OHIC") on Exchange (Health Source RI) products. That exclusion is an industry standard.

Another glaring defect in H 7082 is that it erroneously counts as "administrative expenses" certain payments that dental plans make that are merely "pass through" expenses that comprise obligations of the carrier's customers – not the plan or carrier itself – and that have nothing to do with the administration or operation of the plan itself. Chief among these are fees or commissions incurred by the customer to external brokers (that are the customer's obligations under separate contracts), but that are billed by the carrier in a "pass through" manner as essentially a courtesy. These fees and commissions are not obligations of the dental plan or carrier at all and should under no circumstances figure into the dental loss ratio. Delta Dental does not have brokers. Brokers are hired by our customers to help them make decisions regarding their benefit plans and the negotiated rates. The customer and the broker establish the commission, and the customer effectively pays it. We do not require customers to retain brokers.

Should you desire additional information on this issue, we would be pleased to provide it, including how the inclusion of even just federal and states taxes and external customer's broker commission pass-through payments as part of the administrative expenses for dental ratio calculation purposes would mostly evaporate the 15% of revenue remaining after imposition of a dental ratio as high as 85% as proposed in H 7082, leaving next to nothing with which to operate the business. The customers' *dental* coverage commissions generally average about 10%, versus the 2% generally applicable to *medical* coverage. And our current State premium tax is presently 2% but could go to 4% if certain proposed legislation is enacted. If taxes and commissions were to be treated as administrative expenses, and we were to have to meet a "high end" minimum dental loss ratio of 85% as proposed in H 7082, that would leave only 3% of the premiums we collect available to run the business, a virtual impossibility.

Also, H 7082 departs from the ACA model in the way it fails to include quality improvement costs as claims expenses. For example, we pay the dentists a value-based care bonus annually that rewards them for delivering quality care to our members. As an example, the metrics include but are not limited to, high risk patients with one or more fluoride treatments, high risk patients with one or more sealants and high-risk patients with two or more cleanings. These and any other quality improvement initiatives (including incentive pool expenses and bonuses paid to providers, as well as costs related to improving health care quality and fraud reduction) should be treated as a claim expense and not as an administrative expense.

The following are additional important considerations pertinent to our opposition to H 7082 as presently drafted:

• The bill purports to be applicable only to "Non-Profit Dental Service Corporations", the only one of which is Delta Dental of Rhode Island, and not *any* other dental plan or dental benefits carrier, including any of the other local and national Rhode Island regulated dental plan carriers that Delta Dental competes with day to day (*e.g.*, BCBSRI; Met Life; United Health Care; Aetna; Cigna; Guardian, etc.). We are unaware of any other medical loss ratio or dental loss ratio ever enacted – or even considered – at either the federal or state level that was not made applicable to all the medical or dental carriers and plans (as applicable) operating in the jurisdiction under the authority of the local insurance commissioner. To do otherwise would be akin to enacting emissions standards for only one auto-maker – or taxes for just one individual, employer, or property owner. This renders H 7082 deeply flawed and unsustainable from a legal perspective.

• Because minimum loss ratios are expressed in terms of a minimum percentage of claims expenses, dental carriers struggling to meet an unreasonably high loss ratio--such as the 85% in H 7082 that also counts as administrative expense items that do not belong there-- will have no choice but to raise premiums and pay out more in claims expense until they reach a level that could cover their administrative costs at the 85% minimum loss ratio level. This would make coverage significantly less affordable and attainable for employers, both small and large, and for individuals.

• Dental coverage is an important component of maintaining a person's overall health. Studies show that cost is the biggest barrier to people obtaining dental care. Today, 92% of Rhode Islanders have some form of dental coverage versus 82% in Massachusetts. In addition, only 2% of our members hit their annual maximum benefits in any given year, and less than 0.5% of claims are denied due to utilization review.

• Also, Delta Dental of Rhode Island's statutory mission as a not for profit is to bring oral healthcare to all Rhode Islanders. We try to fulfill this mission through our philanthropy. We have donated millions of dollars throughout the years to expand dental clinics at the state's federally qualified health centers, such as Thundermist, Blackstone Valley, Providence Community Health Centers and Wood River Health. We are also a major sponsor of the Samuels Sinclair dental clinic at RI Hospital, the RI Mission of Mercy, The RI Free Clinic and CareLink, which combined serve hundreds of thousands of Rhode Islanders each year. In addition, we support many other charitable causes. Attached you will find a listing of the charities we supported in 2023. These undertakings would become impossible if they were to be counted as administrative expenses for dental loss ratio purposes.

• As the healthcare industry continues to address nationwide workforce shortages, a large focus of Delta Dental of Rhode Island's community support has been centered on strengthening the talent pipeline in Rhode Island's oral health sector, including an expansion of CCRI's dental clinic/learning labs, allowing for a 20% increase in enrollment in the state's only dental hygiene program. We created the Delta Dental of Rhode Island scholarship at CCRI, which is given to graduating hygienists committed to working in Rhode Island following graduation. Delta Dental is partnering with Rhode Island Hospital to create the state's first oral surgery residency program. And we've invested in oral surgery scholarships for Rhode Islanders at Tufts Dental School. Delta Dental continues to provide financial support to the Rhode Island Health Professionals Loan Repayment Program.

• A research study conducted by the national Milliman consulting group in connection with a Massachusetts ballot initiative imposing a minimum dental loss ratio predicted that dental insurance premiums could increase by 38% by reason of that measure. And the measure involved a lower minimum dental loss ratio than H 7082 proposes. It also gave the Insurance Commissioner discretion to

exclude state and federal taxes, pass through external brokers' commissions as administrative expenses and to include quality measures as claims expenses.

- While dentists certainly deserve to be paid reasonably for their services, they are overarchingly the beneficiaries of H 7082. Respectfully, it bears noting that study after study, including those compiled by the ADA, have ranked Rhode Island dentists as being among the very top in the nation in terms of average incomes.

Thank you for your consideration of these issues. We would be pleased to provide such additional information as you desire, and to continue to work with you and the other stakeholders toward a more balanced version of dental loss ratio legislation.

We believe the measure should begin as a detailed annual reporting bill that will inform the complex matter of the actual calculation methodology for a future minimum loss ratio (similar to what has occurred under the ACA and in most other states).

Sincerely,

Richard A. Fritz
Senior Vice President &
Chief Financial Officer