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November 2, 2023

Deputy Commissioner Kevin Beagan
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

RE: DOI Docket No. G2023-01: Proposed draft of 211 CMR – 156.00

Dear Mr. Beagan,

Thank you for the opportunity to submit the following comments on behalf of the Massachusetts Dental Society (MDS) in response to the draft regulations (211 CMR – 156.00) promulgated by the Division of Insurance (DOI) to implement Chapter 28 of the Acts of 2022, "An Act to Implement Medical Loss Ratios for Dental Benefit Plans" (the "Dental MLR Act" or the "Act"). We are grateful for the tremendous amount of work that has been put into the drafting of these regulations by the DOI.

As the representative body of over 5000 dentists in the Commonwealth of Massachusetts, we would like to continue to work to ensure that the draft DOI regulations best serve individuals in the Commonwealth in receiving appropriate dental care while following the clear intent of the Act which was approved by the voters with a resounding 72% in the Fall of 2022.

Attached are our redlined modifications, tracked for your convenience, showing the specific changes we would like to see in the regulations.

Below are additional comments that capture areas we believe are of key importance and require further review.

I. Actual Dental Loss Ratio (DLR):

A. Numerator:

The change from "costs" to "claims" "paid" has multiple reasons. First of all, "claims" is a defined term in the 211 CMR 156 regulations and leaves no room for misunderstanding. Secondly, "costs" may or may not be paid, and so "paid" is a necessary add-on. The insurer must not just recognize the cost, but must also pay the cost (in a way that ensures it reaches the provider) as part of their obligation.

Changing the words "combined with" to "plus qualified" before Quality Improvement Activity (QIA) expenses adds clarity, because it indicates that QIA is an allowed *addition* of the DLR numerator. Furthermore, the term "qualified" clarifies that QIA's added to the numerator must qualify, which effectively leads the reader to study what actually qualifies as QIA in the QIA definition. Again, this is meant for clarity and guidance to the reader.

Of critical importance, we also would like to address that the numerator of the Actual DLR includes a reference to Fraud, Waste, and Abuse Expenditures**.** This expenditure simply should not be in the numerator for multiple reasons:

1. The controlling statute (at MGL 176X 2(b)) places Fraud expenses in the category of "Administrative Expenses," which is the 17% component of the DLR (not the 83%). Specifically, Section 2 (b)(iv) refers to "utilization review" as a subcategory in these Administrative Expenses. This was specifically placed in the Administrative Expense category to include fraud control in administrative expenses. Therefore, the regulations should reflect all Fraud Control only in the 17% component of the DLR.

2. Fraud Expenses are included in this draft regulation's "Total Administrative Expenses" (at 156.06(2)(d)(12)(g)- Methodology for Calculating and Reporting Dental Loss Ratio).

This section specifically states:

"....the following items shall be deemed to be an Administrative Cost Expenditure for the purposes of calculating and reporting the Dental Loss Ratios...."

The items that follow include:

(4) Claims Operations

- includes *Fraud Investigation* - defined at 156.06(1)(d)).

(5) Dental Administration Expenses

- includes *Fraud Detection and Prevention)* - defined at 156.06(1)(i)).

Therefore, the draft regulations themselves do not place Fraud, Waste, and Abuse Expenditures in the DLR numerator at all. They are in "Total Administrative Expenses."

Recoupments for Fraud, Waste, and Abuse should, however, be placed in the numerator of the DLR. For this reason, we propose an edit from the term "Expenditure" to "Recoupments" in the DLR numerator.

The reason that Fraud, Waste, and Abuse Recoupments belong in the numerator is because recoupments have the effect of reversing "claims paid" (rendering them unpaid). These recoupments must be accounted for in the numerator, or an insurer would be able to evade the purpose of the 83% minimum DLR through aggressive and unfair utilization control tactics, which was never the intent of MGL 176X.

Therefore, the word "minus" was placed before the term "Fraud, Waste, and Abuse" for this reason, which now reads in full as "minus Fraud, Waste, and Abuse recoupments" to capture the true intent of the DLR numerator - which is to capture "net" claims paid (paid minus recoupments) plus QIA.

B. Denominator:

Please see the edits in Attachment A - which clarify that only taxes that are the legal responsibility of the insurance purchaser (paid together with their insurance premium payment) may be reduced from the DLR denominator. We believe these edits provide greater clarity.

II. Dental Loss Ratio for Rebate Calculation:

Our edits to this definition are critical, because the regulation is not tracking the enabling statute. MGL 176X 2(d) requires a 12 month period and 30 day notice after that 12 month period.

Additionally, this definition should also be changed to identically incorporate our proposed edits to the Actual DLR definition (involving Fraud and Taxes - Attachment A).

For long-term regulation fidelity, we propose shortening this definition by pointing back to the master language in the "Actual Dental Loss Ratio" (rather than being repetitive). By doing so, should the Actual Dental Loss Ratio change in the future, these definitions would automatically track those changes, maintaining long-term fidelity of the regulation.

III. Projected Dental Loss Ratio:
For long-term regulation fidelity, we also propose shortening this definition by pointing back to the master language in the "Actual Dental Loss Ratio."

IV. Claims:
In past testimony during the formulation of dental MLR calculations, we emphasized that there are instances where payments are made to subscribers that may not reach providers for treatments performed. For example, when patients see a dental provider who is “out of network,” many insurers refuse to follow the patient’s request that payment for covered services goes directly to the provider. Therefore, we strongly support the draft regulations definition of “Claims” (as defined in 156.03: Definitions) as “claims paid by a Dental Benefit Plan to Dental Providers.”

Thank you for the opportunity to submit these comments on the draft regulations 211 CMR 156. We look forward to seeing the final draft and templates for review. Please contact me at kmonteiro@massdental.org or 800.342.8747 if you have any questions about these comments.

Respectfully submitted on behalf of the Massachusetts Dental Society.

Dr. Abdul Abdulwaheed, D.M.D.
President

Kevin Monteiro
CEO and Executive Director

211 CMR 156.00: DENTAL INSURANCE

Section

156.01: Purpose

The purpose of 211 CMR 156.00 is to implement the provisions of M.G.L. c. 176X.

156.02: Applicability and Scope

211 CMR 156.00 applies to all Dental Benefit Plans offered, made effective, issued, renewed, delivered or issued for delivery to any Individual, member of a Group Association, or Employer Group whether issued directly by a Carrier, through the Connector, or through a Group Association.

156.03: Definitions

Actual Dental Loss Ratio. Incurred Dental Care ~~costs~~ claims paid during a specified 12-month period for covered dental services ~~combined with~~plus qualified Quality Improvement Activity expenses ~~and~~ minus Fraud, Waste and Abuse ~~Expenditures~~recoupments, the total of which is then divided by earned dental premiums (premiums earned during the calendar year) reduced by Federal and State Taxes, Assessments and Licensing or Regulatory Fees that are the responsibility of the purchaser (consumer/ group/ patient member).

Actuarial Opinion. A signed written statement by a qualified actuary, which certifies that the actuarial assumptions, methods, and contract forms utilized by the Carrier in establishing premium rates for Dental Benefit Plans comply with all the requirements of M.G.L. c. 176X, 211 CMR 156.00, and any other applicable law.

Base Rates or Group Product Base Rates. The base rate to be charged to Individuals and their Dependents and/or Businesses for all Eligible Employees and Eligible Dependents prior to the application of Rating Adjustment Factors.

Carrier. An insurer or other entity offering insured Dental Benefit Plans in the Commonwealth, which may include an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under chapter 176G, or a dental service corporation organized under M.G.L. c. 176E.

Comment: Placing Fraud and Waste "expenditures" allows the insurer to weaponize patient funds in an unlimited fashion to stop MLR from spreading around the country - this MUST be removed from the numerator, especialily since MGL 176X 2b deems it an administrative expense (this also mirrors 211 CMR 147.04). However, Fraud and Waste "clawbacks/recoupments" should reduce claims paid towards the numerator.

Comment: According to MGL 176X (and this draft regulation at 156.06(2)(d)(12)(g)): "The following items shall be deemed to be an administrative cost for purposes of calculating and reporting the medical loss ratio:.... (iv) claims operations expenses, (v)....utilization expenses.....(ix) State and Federal Tax expenses." Based on their definitions of these categories at 156.06, the MLR numerator should not include these categories. Specifically, the numerator should not increase by Fraud "expenses." Rather, it must decrease by Fraud/ Waste "recoupments." For this reason, plus and minus have been added to clarify the role of QIA and Fraud recoupments. Also, the denominator should not reduce by taxes, since they are in the 17% for "purposes of calculating the medical loss ratio." "Assessments" (if used) should be defined to avoid such things as Real Estate Assessments from being mis-applied.

Comment: "May" is as modal verb (showing a possibility placeholder, rather than assuredness). See next comment.

Comment: This is in MGL 176X and should be here as an anticipatory placeholder, in the event that MGL 176G allows a stand-alone plan to be issued under 176G

Claims. Total Dental Services claims paid by a Dental Benefit Plan to Dental Providers for activities that are directly related to patient care.

Commissioner. The Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6, or their designee.
Connector. The Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q.

Dental Benefit Plan or Plan. Any Stand-Alone Dental Benefit Plan that covers oral surgical care, Dental Services, dental procedures, or benefits covered by any individual, general, blanket, or group policy of insurance issued by a Carrier.

Dental Care. ~~The~~Any diagnosis or treatment (preventative or otherwise) ~~or prevention of dental disease associated with~~ of teeth and their supporting structures~~.~~

Dental Loss Ratio for Rebate Calculations. A calculated ratio that takes into consideration ~~an average of~~ the prior ~~three~~ annual (12 months) Actual Dental Loss Ratio~~s~~,and the credibility of the information ~~and offsets that are permitted for Quality Improvement Expenses and Fraud, Waste and Abuse Expenditures, and Federal and State Taxes, Assessments and Licensing or Regulatory Fees.~~

Comment: This is not consistent with MGL 176X 2(d), which requires a 12 month period and 30 day notice after that 12 month period. Additionally, the only permitted offset for the numerator is QIA, since Fraud, Taxes, and Licensing is explicitly identified in MGL 176X -2b, (and section 156.06 d & i of this regulations draft) as administrative expenses).

Dental Provider. A practitioner that is appropriately licensed to provide Dental Services.

Dental Service. The dental services ordinarily provided by registered dentists and dental practices in accordance with accepted practices in the community where the services are ren-dered.

Division. The Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Eligible Dependent. The spouse or child of an Individual or Business' Eligible Employee, subject to the applicable terms of the Dental Benefit Plan covering such Individual or Eligible Employee. The child of an Individual or Eligible Employee shall be considered an Eligible Dependent until at least the child's 26th birthday or without regard to age, so long as the dependent, who is covered under the membership of their parent as a member of a family group, is mentally or physically incapable of earning their own living due to disability.

Eligible Employee. Any Individual employed by an employer, including seasonal and temporary staff, but excluding business owners and those holding more than 2% of stock ownership.

Employer Group or Business. Any sole proprietorship, firm, corporation, partnership or other entity that employs Eligible Employees.

Financial Impairment. A condition in which, based on the overall condition of the Carrier as determined by the Commissioner, the Carrier is, or if subjected to the provisions of 211 CMR 156.00 could reasonably be expected to be, insolvent, or otherwise in an unsound financial condition such as to render its further transactions of business hazardous to the public or its policyholders or Members, or is compelled to compromise, or attempt to compromise, with its creditors or claimants on the grounds that it is financially unable to pay its Claims.

Federal and State Taxes, Assessments and Licensing or Regulatory Fees. Incurred federal and state income, premium or other taxes and assessments, and licensing or regulatory fees associated with a Carrier's Dental Benefit Plans.

Fraud, Waste and Abuse Expenditures. Carrier costs to reduce and prevent fraudulent, wasteful, or abusive Dental Care to the extent that Carriers can recover money from their efforts to reduce and prevent fraudulent, wasteful, or abusive Dental Care.

Comment: Fraud prevention and investigation are administrative costs according to MGL 176X (and this proposed regulation, which mirrors 211 CMR 147.04)- Fraud expenditures must be cost controlled- which is why it cannot be part of the 83% figure - it creates opportunity for abuse.

Group Association. A group formed as an association or a trust, which may obtain insurance coverage for the benefit of members of one or more associations.

Health Maintenance Organization or HMO. An entity licensed to do business in Massachusetts under M.G.L. c. 176G. Although HMOs may offer dental benefits as part of an HMO plan, HMOs are not currently licensed to offer Stand-Alone Dental Benefit Plans.

Comment: Changes to MGL 176G should be anticipated, and this should be included in this regulation, since the Statute includes and anticipates it.

Individual. An individual who is a Resident of the Commonwealth.

Insured. Any policyholder, certificate holder, subscriber, Member, or other person on whose behalf the Carrier is obligated to pay for and/or provide Dental Care services.

Large Group. Employer Groups that employ 51 or more Eligible Employees.

Market. The Individual, Group Association, Small Group, and/or Large Group Market(s) in which a Carrier offers a Dental Benefit Plan.

Member. Any person enrolled in a Dental Benefit Plan.

Projected Dental Loss Ratio. ~~Dental Care costs~~ The projected Actual Dental Loss Ratio to be incurred during a prospective 12-month (annual) specified period. ~~for covered Dental Services combined with Quality Improvement Activity expenses and Fraud, Waste and Abuse Expenditures, and then divided by projected earned dental premiums reduced by Federal and State Taxes, Assessments and Licensing or Regulatory Fees.~~

Comment: This is unnecessarily repetitive, and should simply refer to the "Actual Dental Loss Ratio" as the master definition that it simply follows in projection modeling.

Quality Improvement Activity (QIA). An~~y~~ activity designed to improve dental quality that is performed equitably by or through a provider to all patients, requires clinical expertise, increases the clinical wellness and promotion of health activities, produces clinical outcomes that can be objectively measured and can produce verifiable results, be 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 supported by criteria issued by professional dental associations that meets all the requirements of 45 C.F.R 158.150(b)). A QIA may include disease management, case management, ~~utilization review,~~ ~~charitable activities,~~ and other dental management expenses. A QIA does not include any activities that are identified under 45 C.F.R. 158.150(c), that have any overlap with administrative expense items specified under M.G.L. c. 176X, § 2(b)(i)-(x), that have any marketing component that displays the name of the Carrier, or that are paid for by the Carrier to any affiliate of the Carrier in any way, either directly or indirectly.

Comment: "An" is more correct term. "Any" invites abuse because it implies tacit approval for activities that undergo little scrutiny.

Comment: The "or" here must be followed by "supported by" in order to stop an insurer from seeing the "or" as an alternative to all the preceding restrictions. This "or" is only meant to identify the type of support criteria that is acceptable (not to be an alternate definition to QIA).

Comment: Neither Utilization Review, nor Charitable activities can be performed "by or through a provider to all patients." Therefore these should be stricken as QIA activities.

Rating Adjustment Factor. A factor that is based on actuarial principles of risk segmentation, that is not restricted by any state or federal rule, and which is applied to a Base Rate to derive the premium that is charged to a particular Individual or Employer Group.

Rating Period. The period for which premium rates established by a Carrier are in effect.

Resident. A natural person living in the Commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a Resident.

Small Group. Employer Groups that employ 50 or fewer Eligible Employees.

Stand-Alone Dental Benefit Plan. An insured plan that primarily provides coverage for Dental Care, where benefits for non-Dental Care are incidental to covered Dental Care benefits.

Trend in Dental Care Expenses. The projected change in Dental Care Costs.

156.04: Coverage Standards
(1) Evidences of Coverage. Carriers are to file all insured Dental Benefit Plans offered under 211 CMR 156.00 with the Division.

(a) All such Plans are to be reviewed for compliance with M.G.L. c. 175, §2B.
(b) For individually issued Dental Benefit Plans, they are to comply with the requirements of 211 CMR 42.00.
(c) For Plans that provide or arrange for the delivery of dental benefits through a network of Dental Providers or use utilization management in the review of the necessity of certain Dental Services, the plans are to comply with the requirements of 211 CMR 52.00, as noted in 211 CMR 52.01.
(d) For Plans that provide or arrange for the delivery of dental benefits through a network of Dental Providers and include dental networks that differ from those of a Dental Benefit Plan's overall network, the Plan should prominently display on all Plan documents, including provider directory materials, a provider network name that distinguishes the network of the Plan from the other networks offered by the Carrier.
(e) For Plans that permit both an in-network and an out-of-network level of dental benefits, the plans are to comply with the requirements of 211 CMR 51.00.

(2) Issuing Coverage.
(a) (1) No Carrier may exclude any Individual, Eligible Employee, or Eligible Dependent from a Dental Benefit Plan on the basis of any impermissible factors, including but not limited to race, color, religious creed, national origin, sex, gender identity, sexual orientation, genetic information, pregnancy, ancestry, age, or status as a veteran.

Comment: Age discrimination should be listed in this section.

(2) No Carrier may modify the coverage of an Individual, Eligible Employee, or Eligible Dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or conditions otherwise covered by the Dental Benefit Plan except as permitted under 211 CMR 156.00.
(3) Every Carrier must make appropriate disclosures in plain language and provide access to information assistance to prospective group Insureds and prospective individual Insureds, as part of its solicitation and sales material, of:
a. renewal provisions;
b. rating limitations according to 211 CMR 156.07; and
c. availability of Dental Benefit Plans; and any dental insurance coverage offering that is limited to a particular service area or to employees that live in the service area.

(b) Carriers are permitted to underwrite Dental Benefit Plans that are issued to Individuals, provided that the applicant completes a dental coverage application and the Carrier uses the information from the application to determine whether to issue coverage based on its policy for underwriting individual dental policies. Carriers may apply waiting periods, deductibles, benefit limitations, or exclusions as a condition of issuing coverage, provided that the applicant is made aware of and is provided with complete written information regarding all conditions that differ from the coverage originally applied for. When issuing individual dental policies, Carriers are required to prominently and clearly identify on the cover page of the policy the renewal conditions of the policy, in a manner that is consistent with the requirements set forth in 211 CMR 42.00.
(c) Carriers are permitted to underwrite Dental Benefit Plans to be issued to Group Associations and may underwrite coverage issued to Individuals through Group Associations, provided that the applicant completes a dental coverage application and the Carrier uses the information from the application to determine whether to issue coverage based on its individual coverage policy. Carriers may apply waiting periods, deductibles, benefit limitations, or exclusions as a condition of issuing coverage, provided that the applicant is made aware of and is provided with complete written information regarding all conditions that differ from the coverage originally applied for. When issuing individual dental policies, Carriers are required to prominently and clearly identify on the cover page of the policy the renewal conditions of the policy, in a manner that is consistent with the requirements set forth in 211 CMR 42.00.
(d) Carriers are permitted to underwrite the issuance of group dental coverage to Employer Groups, but are not permitted to underwrite coverage issued to Eligible Employees and their Eligible Dependents. Carriers may apply waiting periods, deductibles, benefit limitations or exclusions as a condition of issuing coverage to an Employer Group, provided that the applicant is made aware of and is provided with complete written information regarding all conditions that differ from the coverage originally applied for. When issuing group dental policies, Carriers are required to prominently and clearly identify within the policy, all continuation of coverage provisions, including but not limited to those required under federal COBRA, in the event employment-based coverage is lost due to a qualifying event.

156.05: Restrictions Relating to Premium Rates
Carriers may develop Base Rates that are based on the collective experience of all Individuals, Group Associations, Small Groups, and Large Groups to which the Dental Benefit Plans are marketed, or Carriers may develop Base Rates for any single or combination of Individual, Group Association, Small Group, or Large Group Markets in which they offer Dental Benefit Plans. Premiums charged must satisfy the following requirements:

Premium Calculations
(1) In calculating the premium to be charged a Carrier shall develop a Base Rate and may develop and use one or more Rating Adjustment Factors, provided that such Rating Adjustment Factors are used in connection with all products offered to those eligible within a Market.
(a) Carriers may develop one Base Rate and set of Rating Adjustment Factors that apply to all Markets; or
(b) Carriers may develop separate Base Rates and Rating Adjustment Factors for each or combination of each of the Markets in which it offers Dental Benefit Plans.

(2) In calculating the premium to be charged, a Carrier shall develop a Base Rate and may develop and use only Rating Adjustment Factors that are based on sound actuarial principles about the segmentation of risk and are not discriminatory under state or federal law.

~~(a) Age Rating Adjustment Factor. If a Carrier applies an age Rating Adjustment Factor, the Carrier must apply the age Rating Adjustment Factor in accordance with guidance provided by the Commissioner.~~

(b) Area Rating Adjustment Factors.

1. The area Rating Adjustment Factor for each distinct region in 211 CMR 156.05(2)(b) must range from not less than 0.8 to not more than 1.2.

2. The permissible regions are based on the following zip code groupings which refer to the first three digits of the zip code for each Business or Individual:

i. 010 through 013;
ii. 014 through 016;
iii. 017 and 020;
iv. 018 through 019;
v. 021 through 022 and 024;
vi. 023 and 027; and
vii. 025 through 026.

except that a Carrier may combine the zip code groupings outlined in 211 CMR 156.05(2)(b)(2)(ii), iii, and iv into one region or combine the zip code groupings outlined in 211 CMR 156.05(2)(b)(2)(ii), iii, iv, and v into one region for all of its Dental Benefit Plans subject to 211 CMR 156.00, or use regions based on groupings of counties that roughly approximate the zip code groupings.

3. If a Carrier chooses to establish area Rating Adjustment Factors, it must apply the Rating Adjustment Factors to all Members of a Market. The area Rating Adjustment Factor for an Employer Group will be based upon the head office location of the Employer Group and the area Rating Adjustment Factor for an Individual will be based on the location of the Individual's residence.

(c) All Other Rating Adjustment Factors.

All other Rating Adjustment Factors may only be used if based on an actuarially sound basis, are considered nondiscriminatory, and only when approved as part of a dental rate filing.

Comment: This is discriminatory (particularly since dental insurance - unlike medical insurance - has maximum limits), and would increase burdens on families with orthodontics aged children and elderly patients. Additionally, these regs (as written in this draft) reference but do not actually provide the referenced "guidance" from the Commissioner - This guidance should be prescribed before the public comment hearing. Regardless, Age Rating should be removed based on its discriminatory nature.

156.06: Submission and Review of Rate Filings

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(1) Definitions. For rate filings submitted pursuant to 211 CMR 156.06(2), the following definitions also shall apply:

(a) Capital Costs and Depreciation Expenses. Excluding Real Estate purchase and depreciation, ~~A~~all expenses associated with depreciation (depreciation for electronic data processing, equipment, software, and occupancy); capital acquisitions (acquisition of capital assets, including lease payments that were paid or incurred during the year); capital costs on behalf of a clinic (expenditures for capital and lease payments incurred or paid during the year on behalf of a clinic; or part of a partnership, joint venture, integration, or affiliation agreement); and other capital (other costs that are directly associated with the incurring of capital costs, such as legal or administrative costs, incurred or paid during the year).

Comment: Real Estate Purchase and Depreciation must be explicitly removed from this section. It should not carry forward into

(b) Charitable Contributions Expenses. All contributions to ~~tax-exempt~~ foundations and charities, not related to the company business enterprises.

Comment: Tax exemption is implicit in Charitable contributions. Adding the words "tax-exempt" creates an opportunity for evasion.

(c) Claim Completion Method. Any actuarial method used to quantify Claims which have been incurred but not yet paid.

(d) Claims Operations Expenses. All expenses associated with Claims adjudication and

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adjustment of Claims, appeals, Claims settlement, coordination of benefits processing, maintenance of the Claims system, printing of Claims forms, Claim audit function, electronic data interchange expenses associated with Claims processing, and fraud investigation.

Comment: Fraud investigation is specifically identified here as an administrative expense. Therefore, it does not belong in the DLR numerator.

(e) Distribution Expenses. All expenses associated with distribution and sale of dental products, including commissions, producer, broker and benefit consultant fees, other fees, commission processing, and account reporting to brokers, agents, and producers.

(f) Financial Administration Expenses. All expenses associated with underwriting, auditing, actuarial, financial analysis, investment-related expenses (not included elsewhere), treasury, and reinsurance.

(g) General Administration Expenses. All expenses associated with payroll administration expenses and payroll taxes (salaries, benefits and payroll taxes); real estate expenses (company building and other taxes and expenses of owned real estate, excluding home office employee expenses and rent [not allocated elsewhere] and insurance on real estate); regulatory compliance and government relations (federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, preparation and filing of financial, utilization, statistical and quality reports, and administration of government programs); board, bureau, or association fees (Board of Directors, Bureau and association fees paid or expensed during the calendar year); other administration (information technology, senior management, outsourcing [not allocated elsewhere], insurance except on real estate, equipment rental, travel [not allocated elsewhere], certification and accreditation fees, legal fees and expenses before administrative and legal bodies, and other general administrative expenses); and negative adjustment for reimbursement from uninsured plans (all revenue receipts from uninsured plans [including excess pharmaceutical rebates and administrative fees net of expenses] and reimbursements from fiscal intermediaries, including administrative fees net of expenses from the government).

(h) Marketing and Sales Expenses. All expenses associated with billing and Member enrollment (group and individual billing, Member enrollment, premium collection, and reconciliation functions); customer service and Member relations (individual, group or provider support relating to membership, enrollment, grievance resolution, specialized phone services and equipment, consumer services, and consumer information); product management, marketing and sales (management and marketing of current products, including product promotion and advertising, marketing materials, changes or additions to current products, sales, pricing, and enrollee education regarding coverage prior to the sale); and product development: (product design and development for new products not currently offered, major systems development associated with the new products. and integrated system network development).

(i) Dental Administration Expenses. All expenses associated with quality assurance and cost containment (dental and disease management and wellness initiatives other than for education), Dental Care quality assurance, appeals, case management, fraud detection and prevention, utilization review, practice protocol development, peer review, outcomes analysis related to existing products, nurse triage, dental management, and other Dental Care evaluation activities; wellness and dental education (wellness and dental promotion, disease prevention, Member education and materials, and outreach services); and dental research (outcomes research, dental research programs, and development of new dental management programs not currently offered, major systems development, and integrated system network development).

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Comment: Fraud detection and prevention are specifically identified here as an administrative expense. Therefore, it does not belong in the DLR numerator.

(j) Minimum Dental Loss Ratio. The Minimum Actual Dental Loss Ratio for the insured Dental

Benefit Plans issued or renewed in Massachusetts is 83%.
(k) Miscellaneous Expenditures Expenses. All other expenses that are not classified expenses, including all collection and bank service charges, printing, office supplies, postage, and telephone (not allocated elsewhere).
(l) Network Operations Expenses. All expenses associated with provider contracting negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, administration of provider capitation and settlements, dentist relations, dental policy procedures, network access fees, and credentialing.

Comment: Section (m) is missing.

(n) Taxes, Assessments and Fines that are pass-through charges belonging to the insurance purchaser, ~~-P~~paid on behalf of the purchaser (consumer/group/patient member) by the carrier to Federal, State or Local Governments or regulatory agencies ~~(as Expenses). All expenses associated with taxes ((~~including, but not limited to, state premium taxes, state and local insurance taxes, federal taxes, assessments, fees, etc). This administrative expense category~~, except~~ excludes charges that belong to the carrier, such as ~~taxes on~~ capital gains tax, state income tax, state sales tax, and other sales taxes not included with the cost of goods purchased); ~~assessments, fees and other amounts paid to regulatory agencies (assessments, fees, or other amounts paid to state or local government,~~It also excludes ~~but does not include~~ taxes, ~~or~~ fines, and ~~or~~ penalties that are the responsibility of the carrier and are paid to any government agency. ~~); and fines and penalties paid to regulatory agencies (penalties and fines paid to government agencies).~~

Comment: This section has been modified to remove ambiguity.

(2) Content of Rate Filings. A Carrier's submission shall be submitted in a format specified by the Commissioner and shall show the company's development of the filed rates, explaining how they apply to each Market in which the Carrier offers coverage. The filing shall contain at least the following information:
(a) Summary rate information for each product, including:
1. proposed rate change compared to rates in effect 12 months before proposed effective date;
2. number of currently enrolled Members impacted by the proposed rate change, presented as:
a. number of Employer Groups and covered employees/dependents renewing by month; and
b. individual accounts and covered Individuals/dependents renewing by month; and
3. maximum increase for any Employer Group or Individual covered under the proposed rate change.
(b) Number of Member months of coverage reported for each of the latest available 12 months for products issued or renewed, as well as the number of Member months projected to be impacted by the proposed rate increase.
(c) A three-year history of premium, dental Claims (including capitation and non-Claims expenses) for the Carrier's Massachusetts book of business and national book of business, separating by Market, where applicable, differentiating among:
1. preventive Dental Care visits and cleanings;
2. basic restorative Dental Services;
3. major Dental Services; and
4. orthodontic care.

The analysis should explain any differences between ~~what is~~the itemization and figures included in the filing and ~~what~~ the itemization and figures ~~normally is~~ included in the Carrier's financial statements. ~~(~~They should otherwise match). The Carrier also should submit proposed assumptions about Trend in Dental Care Expenses. Annual price and use assumptions for Trend in Dental Care Expenses for fee-for-service expenses should be provided for each year in the projection period, and the Carrier must indicate how many months of each year are used in the analysis. The Carrier should indicate where leverage assumptions are included. Trend in Dental Care Expenses for fee-for-

Comment: Please add specific language for clarity (including itemization and figures).

Comment: Please add specific language for what is required to be reported here. Please add this to the reporting template.

service expenses should reflect provider price increases whereas utilization may include mix of services and mix of providers. The Trend in Dental Care Expenses for fee-for-service expenses information should include the actuarial basis for all changes in Trend in Dental Care Expenses for fee-for-service expenses, including all relevant studies used to derive the factors.

(d) Starting with the Jan 1 to December 31 2024 period rate-filing, ~~T~~the Carrier's administrative expenses and per Member per month administrative expenses relevant to products issued or renewed and used in the development of the filing, for the two years prior to the submission of the rate filing for each of the following categories:

1. expenses for capital costs and depreciation;
2. expenses for charitable contributions;
3. expenses for Claims operations;
4. expenses for distribution;
5. expenses for financial administration;
6. expenses for general administration;
7. expenses for marketing and sales;
8. expenses for dental administration, with specific detail on administration costs related to programs that improve Dental Care quality ~~;~~ -
9. expenses for miscellaneous expenditures described in detail;
10. expenses for network operations;
11. expenses for taxes, assessments and fines paid to federal, state or local governments; and
12. total administrative expenses [subtotaling 211 CMR 156.06(2)(d)1. through 11.]. Expressed as a percentage, this line item represents 100% of aggregate premiums in a prescribed 12-month coverage period minus the Projected Dental Loss Ratio (the minimum of which is identified in 156.06 (1)(j)).

The Carrier also should submit projected increases in administrative expenses per Member per month that the Carrier is using to project administrative expenses forward to the period for which the rates will be effective. The trend information should include an explanation for all significant changes in the Carrier's administrative expenses due to one-time costs, including where changes in administrative expenses may be caused by regulatory requirements or efforts to contain Dental Care delivery costs, an explanation of the projected cost and cost per Member per month that can be attributed to each regulatory requirement or effort to contain Dental Care delivery costs, and the method that the Carrier is using to allocate any companywide expenses to the dental line of business.

(e) The Carrier's contribution to surplus, relevant to products issued or renewed according to M.G.L. c. 176X, both in the aggregate, on a normalized per-Member-per-month basis, and as a percentage (%) of premium for the two years prior to the submission of the rate filing. The Carrier also should identify the contribution to surplus included in the rate filing on a per-Member-per-month basis and as a percentage (%) of premium and should provide a detailed explanation of the reasons that the contribution to surplus has been filed at that level, as well as the contribution to surplus levels that the Carrier is using in all other lines of coverage. The Carrier should describe the method used to quantify the contribution to surplus in the proposed rates.

(f) The three-year historic Actual Dental Loss Ratio for the rates, relevant to products issued or renewed, and the Projected Dental Loss Ratios for the one-year period during which rates will be in effect.

(g) Methodology for Calculating and Reporting Dental Loss Ratio (DLR), for the purposes of M.G.L. c. 176X, § 2(d), the DLR of a Dental Benefit Plan shall be calculated and reported on a calculation worksheet defined by the Commissioner and based on the current federal methodology used by the federal Centers for Medicare and Medicaid ~~Medicare~~

Comment: For clarification, this edit clarifies that the rates submitted for Jan 1 2024 must include the prior 2 years data.

Comment: "Administration" added for clarity.

Comment: This line item should explicitly state that it is meant to include all (and only) things in the 17% administrative expense figure.

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Comment: Please provide this worksheet for our comment?

Comment: Please provide a link to this for our comment.

Services (CMS) for calculating and reporting Medical Loss Ratio rounded to the third decimal place. Unless contrary to the current CMS methodology for calculating and reporting DLR, or unless otherwise determined by the Commissioner, the following items shall be deemed to be an Administrative Cost Expenditure (none of which may be included in the numerator of any Dental Loss Ratio of this regulation) for the purposes of calculating and reporting the Dental Loss Ratios of Dental Benefit Plans for M.G.L. c. 176X:

1. Financial administration expenses;
2. Marketing and sales expenses;
3. Distribution expenses;
4. Claims operations expenses;
5. Dental administration expenses, such as disease management, care management, utilization review, and dental management activities;
6. Network operations expenses;
7. Charitable expenses;
8. Board, bureau or association fees; and
9. Payroll expenses.

(h) A detailed description of all cost containment programs the Carrier is employing or will employ during the Rating Period to address Dental Care delivery costs and the realized past savings and projected savings from all such programs.

(i) An Actuarial Opinion and an actuarial memorandum developed and prepared by ~~a~~ qualified members of the American Academy of Actuaries that includes the following:

1. Effective dates of the filed rates;
2. Whether the company intends to trend filed rates using a trend factor for future effective dates;
3. The trend factor and annual trend assumption that includes the cost trend assumption;
4. Trend exhibits supporting how trends were derived.
5. An exhibit that shows the most recent available experience, both Massachusetts and national.
6. A statement describing the rating formula and rating factors used to calculate rates;
7. A description of how the proposed rates were developed, including experience used, trend assumptions used, and any other adjustments used; and
8. The average rate increase resulting from the proposed rates.

(j) A rate manual and demonstration of the used manual to calculate a sample premium rate.

(k) A benefit description of the products for which the rates are being proposed, including a summary of benefits as well as cost sharing elements (deductibles, coinsurance, copayments, benefit limits, out-of-pocket maximums) by service categories.

(l) Any other information requested by the Commissioner.

(3) Review of Rate Filings.

(a) All Base Rate changes and Rating Adjustment Factors are subject to disapproval if they do not meet the requirements of 211 CMR 156.00.

(b) A Carrier shall respond to any request for additional information by the Division within five business days of the date of the Division's request. Failure to respond to the Division's request within five business days may result in a delay of the Division's review of the filing and a delay in the proposed effective date of the filed rates.

(c) Every Carrier shall include with any submission under 211 CMR 156.06 a cover letter summarizing the content in 211 CMR 156.06(2)(d), (e) and (f). Base Rates will be

Comment: This includes Fraud Prevention and Investigation. So the ACTUAL MEDICAL LOSS RATIO numerator should not "add" in Fraud Prevention and Investigation - because it "shall be deemed an Administrative Cost Expenditure for purposes of calculating and reporting the Dental Loss Ratio." Furthermore MGL 176X 2(b) also deems Claims Operations Expenses as an "administrative cost expenditure for the purposes of calculating and reporting the medical loss ratio."

Comment: The definition (at 156.06(7)(i)) includes Fraud detection and prevention, which also supports the notion that the numerator of the Medical Loss Ratio should not "add" in any Fraud expenses as part of the 83% minimum loss ratio.

presumptively disapproved as excessive if the rate filing does not meet the following standards:
1. Administrative Expense Standards. Base Rates will be presumptively disapproved if the filing's projected administrative expense loading component, not including taxes and assessments, Quality Improvement Activity expenses, and fraud and abuse detection, increases by more than the Dental Services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted).
a. The projected administrative expense loading component is the per Member per month administrative expense described in 211 CMR 156.06(2)(d)12, plus the producer commission expense.
b. The most recent calendar year's increase in the Dental Services consumer price index (U.S. city average, all urban consumers, not seasonally adjusted) shall be calculated by dividing the index value for the December period preceding the date of the filing by the same index value from the December period one year earlier.
2. Contribution to Surplus Standards. Base Rates will be presumptively disapproved as excessive if the rate filing's contribution to surplus loading component exceeds 1.9% of the total filed Base Rate. The contribution to surplus loading component shall represent the per Member per month contribution to surplus amount submitted in 211CMR 156.06(2)(e).
3. Projected Dental Loss Ratio Standards. Base Rates will be presumptively disapproved as excessive if the rate filing's projected aggregate dental loss ratio for all plans offered across all dental Markets is less than the Minimum Dental Loss Ratio.
a. The projected aggregate dental loss ratio shall be reported as submitted in 211 CMR 156.06(2)(f).

Comment: This should be included in this section, since it is an administrative expense - and this section is for administrative loading. This further supports the argument that Fraud expenses do not belong as an "addition" in the DLR numerator.

Comment: The word aggregate is not well defined. Please characterize further for clarity.

(4) Presumptive Disapprovals Issued Pursuant to M.G.L. c. 176X, § 2(d)
(a) Rate filings may be presumptively disapproved by the Commissioner as described in 211 CMR 156.06(3).
(b) If a Carrier's filing is presumptively disapproved, the Commissioner shall notify the Carrier in writing within 5 business days of the annual rate filing submission stating the reason(s) for the presumptive disapproval.
(c) New Dental Benefit Plans whose initial Base Rates are presumptively disapproved may not be offered.
(d) Within 10 days of receipt of the presumptive disapproval, the Carrier shall communicate to all employers and Individuals covered under a Dental Benefit Plan approved under M.G.L. c. 176X that the proposed rate change has been presumptively disapproved and will be subject to a public hearing at the Division.
(e) In the event of a presumptive disapproval, the Carrier shall comply with the following procedures:
1. the Carrier shall not quote, issue, make effective, deliver, or renew Dental Benefit Plans in the Commonwealth using disapproved Base Rates. The Carrier shall quote, issue, make effective, deliver, or renew all Dental Benefit Plans using Base Rates in effect 12 months prior to the proposed effective date of the presumptively disapproved Base Rates. In recalculating premiums, the Carrier must apply the Rating Adjustment Factors in effect 12 months prior to the proposed effective date of the presumptively disapproved Base Rates;
2. the Carrier shall recalculate applicable rates for all affected Dental Benefit Plans and shall issue rate quotes and make all Dental Benefit Plans available through all

distribution channels, but in no event more than ten calendar days after the Carrier's receipt of the presumptive disapproval;
3. the Carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected Individuals and groups.
(f) With respect to the hearing for the presumptive disapproval:
1. the public hearing shall be scheduled within 15 calendar days of the submission of a complete rate filing; and
2. notice of the public hearing will be given to, or advertised in, newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford, and Lowell and posted to the Division's website.
3. The purpose of the public hearing will be to provide the Carrier with the opportunity to rebut the reasons for the presumptive disapproval. For purposes of 211 CMR 156.06(5)(f) the administrative record to be considered at the public hearing will be limited to the materials and information included in the Carrier's presumptively disapproved rate filing submitted pursuant to 211 CMR 156.06.

(5) Disapprovals Issued Pursuant to M.G.L. c. 176X, § 2(c)
(a) Rate filings also shall be disapproved by the Commissioner if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate, or unfairly discriminatory, or do not otherwise comply with the requirements of M.G.L. c. 176X or 211 CMR 156.00.
(b) Changes to filed Rating Adjustment Factors shall be disapproved by the Commissioner if found to be discriminatory or not actuarially sound.
(c) New Dental Benefit Plans whose initial Base Rates are disapproved may not be offered.
(d) If the Commissioner disapproves a Carrier's proposed Base Rate(s) or proposed changes to Rating Adjustment Factor(s), the Commissioner shall notify the Carrier and state the reason(s) for the disapproval, including whether the disapproval is presumptive. Unless otherwise determined by the Commissioner, if the Commissioner disapproves a Carrier's proposed Base Rate(s) or proposed changes to Rating Adjustment Factor(s), the Commissioner shall notify the Carrier in writing no later than August 15 of the year preceding the rates' effective date, stating the reason(s) for the disapproval.
(e) In the event of a disapproval, the Carrier shall comply with the following procedures:
1. the Carrier shall not quote, issue, make effective, deliver or renew Dental Benefit Plans in the Commonwealth using disapproved Base Rates and the Carrier shall quote, issue, make effective, deliver, or renew all Dental Benefit Plans using Base Rates and Rating Adjustment Factors as in effect 12 months prior to the proposed effective date of the disapproved Base Rates;
2. the Carrier shall recalculate applicable rates for all affected Dental Benefit Plans and shall issue rate quotes and make all Dental Benefit Plans available through all distribution channels, including Intermediaries, the Connector, licensed insurance producers and the Carrier's website, but in no event more than ten calendar days after the Carrier's receipt of the disapproval;
3. the Carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected Individuals and groups.
(f) The Commissioner retains the right to disapprove a rate filing for reasons other than those identified upon review of the rate filing.
(g) Hearings on disapprovals issued pursuant to M.G.L. c. 176X, §(2)(c):
1. within 10 days of receipt of the disapproval, the Carrier may request a hearing on the disapproval;

2. the Division shall schedule a hearing within 15 calendar days of receipt of the Carrier's request;
3. the purpose of the hearing will be to consider whether the disapproval is supported by substantial evidence and not based upon an error of law; and
4. The Commissioner shall issue a written decision either affirming or rejecting the disapproval within 30 days after the conclusion of the hearing.

(6) Appeals. Any final order, decree, or judgment of the Massachusetts Superior Court or appellate court modifying, amending, annulling, or reversing a decision of the Commissioner disapproving a rate filing, and any further decision of the Commissioner pursuant to such an order, decree, or judgment that affects the overall rate not disapproved shall be effective as ordered.

(7) Maintaining Records. Every Carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 156.00.

(8) Methodology for Calculating and Reporting Refund, Rebate or Credit Calculations.
(a) Unless otherwise determined by the Commissioner, for the purposes of M.G.L. c. 176X, §2(d), Carriers are to calculate and submit a rebate calculation form as designated by the Commissioner each calendar year (Beginning 2025) by July 31st for the previous calendar year. When completing the rebate calculation form, Carriers are to use the Dental Loss Ratio for Rebate Calculations that applies in the year for which the calculation was completed.

Comment: Please provide for review.

Comment: Does this begin July 31, 2024? or 2025? The year of commencement should be identified here as 2025.

(b) If the calculation illustrates that a refund or rebate is warranted, the Carrier shall submit a detailed plan for the Commissioner's approval that will provide a detailed description of the manner in which the Carrier will refund the excess premium to those Individuals or employers who were covered during the prior calendar year, or an explanation of the reasons that the Carrier proposes not to make a refund or rebate. The amount of the rebate will be based on each Individual's or Employer Group's relative share of the premiums that were paid to the Carrier during the prior calendar year.
(c) If the calculation illustrates that a refund or rebate is warranted, a Carrier shall communicate within 30 days to all Individuals and Employer Groups that were covered under Dental Benefit Plans during the relevant 12-month calendar year that such Individuals and Employer Groups qualify for a refund which may take the form of either a refund on the premium for the applicable 12-month period, or if the Individual or Employer Group is still covered by the Carrier, a credit on the premium for the subsequent 12-month period.
(d) The basis for all refunds issued shall equal the amount of a Carrier's earned premium that exceeds that amount necessary to achieve the Minimum Dental Loss Ratio (calculated using the Dental Loss Ratio for Rebate Calculations), as reported to the Commissioner. The Commissioner may authorize a waiver or adjustment of the refund requirement if the Commissioner determines premium credits are not feasible and that issuing such refunds would result in Financial Impairment for the Carrier, or if the Commissioner determines that such refunds are *de minimus* because the cost of distributing any refund exceeds the value of the refund itself. The aggregate of any *de minimus* amount not refunded shall be used to reduce overall premiums.

Comment: This should be added for Clarification.

(e) Refunds shall be paid annually by August 30th, or another date as determined by the Commissioner, following the calendar year of the rebate calculation.
(f) Carriers who issue refunds shall keep records of all refunds made to affected Individuals and groups for inspection by the Division.
(g) No Individual or Employer Group may assign its or their rights to such premium adjustments to another person or entity.
(h) If a Carrier fails to make refunds, rebates, or premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits as they deem necessary.

156.07: Annual Comprehensive Financial Statement.
On or before March 31, the Division will collect reports that contain at least the following information in a format specified by the Commissioner. Each Carrier shall submit a detailed report on a form approved by the Commissioner of the costs incurred by the Carrier as of December 31st of the most recent calendar year.

Comment: Please provide this form for our comment.

(1) Market group size, including:
(a) Individual;
(b) Small groups of one to five, six to ten, 11 to 25, and 26 to 50; and
(c) Large groups of 51 to 100, 101 to 500, 501 to 1000, and greater than 1000.

(2) Lines of dental business, including:
(a) Non-network Dental Benefit Plans issued by an insurer licensed under M.G.L. c. 175;
(b) Non-network Dental Benefit Plans issued by a nonprofit hospital service corporation under M.G.L. c. 176A or by a nonprofit hospital service corporation under M.G.L. c. 176B;
(c) Dental Benefit Plans that include a preferred provider arrangement issued under M.G.L. c. 176I;
(d) Dental Benefit Plans issued through the Group Insurance Commission under M.G.L. c. 32A; and
(e) Medicaid Program dental plans under Title XIX of the Social Security Act and M.G.L. c. 118E et seq.

Comment: 176 E & 176G (that are stand alone plans) are required to report according to MGL 176X. Any plan under 176G that is not a stand-alone plan, is not required to report, but this should still be included here in case a stand-alone plan under 176G were to be allowed in the future.

(3) The Annual Comprehensive Financial Statement shall report the following information for each Market size and each line of business:
(a) Enrollment Information.
1. Number of distinct Employer Groups covered on December 31st.
2. Number of subscriber Members covered including:
a. Number of subscriber Members covered on December 31st;
b. Number of subscriber Member months covered in prior calendar year; and
c. Average number of subscriber Members for prior calendar year.
3. Number of total subscriber and dependent lives covered including:
a. Number of total subscriber and dependent covered lives on December 31st ;
b. Number of total subscriber and dependent covered life months covered in calendar year; and
c. Average number of subscriber and dependent covered lives in calendar year.
(b) Income Statement Information.
1. Premiums, including earned premiums (premium earned during the calendar year) and net earned premiums (direct premiums earned, plus premium assumed, and less reinsurance ceded).

Comment: The definition within the parentheses was transposed into the Actual DLR definition from this section for clarity and convenience for the reader.

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2. Incurred Claims, including direct Claims paid during the calendar year on services rendered during the calendar year, unpaid Claims reserves on service rendered or Claims incurred during the calendar year, changes in contract reserves, the Claims-related portion of reserves for contingent benefits and lawsuits, and ex-perience rating refunds paid or received and reserves for experience rating re-funds with negative adjustment for Dental Care receivables and for reinsurance recoverables.
3. Actual Dental Loss Ratio, as defined in accordance with 211 CMR 156.03.
4. Investment gains and losses:
a. Investment income, including that part of a Carrier's income that stems from the interest and dividends earned on the stocks and bonds it owns or the return on any other invested funds; and
b. Net Realized capital gains and losses, including the difference between the amount received from the sale or disposal of an asset and its carrying value.
5. Financial administration expenses, including all costs associated with underwrit-ing, auditing, actuarial, financial analysis, investment-related expenses (not in-cluded elsewhere), treasury, reinsurance, and outside benefit consultants.
6. Marketing and sales expenses:
a. Billing and Member enrollment, including all costs associated with group and individual billing, Member enrollment, premium collection, and rec-onciliation functions;
b. Customer services and Member relations, including all costs associated with individual, group or provider support relating to membership, en-rollment, grievance resolution, specialized phone services and equipment, consumer services and consumer information;
c. Product management, marketing and sales, including all costs associated with the management and marketing of current products, including prod-uct promotion and advertising, marketing materials, changes or additions to current products, sales, pricing, and enrollee education regarding cov-erage prior to the sale; and
d. Product Development, including all costs associated with product design and development for new products not currently offered, major systems development associated with the new products, and integrated system network development.
7. Distribution expenses, including all costs associated with the distribution and sale of products, including commissions, insurance producer and benefit consultant fees, intermediary fees, commission processing, and account reporting to insur-ance producers.
8. Claims operations expenses, including all costs associated with Claims adjudica-tion and adjustment of Claims, appeals, Claims settlement, coordination of ben-efits processing, maintenance of the Claims system, printing of Claims forms, Claim audit function, electronic data interchange expenses associated with Claims processing, and fraud investigation.
9. Dental administration expenses:
a. Quality assurance and cost containment, including all costs associated with dental and disease management and wellness initiatives (other than for ed-ucation), Dental Care quality assurance, appeals, case management, net-work access fees, fraud detection and prevention, utilization review, prac-tice protocol development, peer review, outcomes analysis related to

existing products, nurse triage, dental management, and other Dental Care evaluation activities;
b. Wellness and dental education, including all costs associated with wellness and dental promotion, disease prevention, Member education and materi-als, and education and outreach services; and
c. Dental research, including all costs associated with outcomes research, dental research programs and development of new dental management programs not currently offered, major systems development, and inte-grated system network development.
10. Network operational expenses, including all costs associated with provider con-tracting negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, admin-istration of provider capitation and settlements, dental policy procedures, dentist relations, dental policy procedures, network access fees, and credentialing.
11. Charitable expenses, including all costs associated with contributions to tax exempt and non-tax exempt foundations, charities, not related to the company business enterprises, and community benefits.
12. Taxes, Assessments and Fines Paid to Federal, State or Local Government:
a. Taxes (premium, real estate, other non-payroll) paid, including all costs associated with state premium taxes, state and local insurance taxes, fed-eral taxes, except taxes on capital gains, state income tax, state sales tax, and other sales taxes not included with the cost of goods purchased;
b. Assessments, fees and other amounts paid to government agencies, includ-ing all assessments, fees or other amounts paid to state or local govern-ment, but does not include any taxes or fines or penalties paid to any government agency; and
c. Fines and penalties paid to government agencies, including all costs asso-ciated with penalties and fines paid to government agencies.
13. General Administration:
a. Payroll administration expenses and payroll taxes, including all costs as-sociated with salaries, benefits, and payroll taxes (not allocated else-where);
b. Real estate expenses, including all costs associated with company building and other taxes and expenses of owned real estate, excluding home office employee expenses, and rent (not allocated elsewhere) and insurance on real estate;
c. Regulatory compliance and government relations, including all costs asso-ciated with Federal and State reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, preparation and filing of financial, utilization, statistical, and quality reports, and administration of government programs;
d. Board, bureau or association fees, including all board of directors, bureau, and association fees paid or expensed during the calendar year;
e. Other administration, including all cost associated with information tech-nology, senior management, outsourcing (not allocated elsewhere), insur-ance except on real estate, equipment rental, travel (not allocated else-where), certification and accreditation fees, legal fees and expenses be-fore administrative and legal bodies, and other general administrative ex-penses;

Comment: Non Tax Exempt should also be included here.

f. Reimbursement from uninsured plans, representing a negative adjustment that would include all revenue receipts from uninsured plans (including excess pharmaceutical rebates and administrative fees net of expenses) and reimbursements from fiscal intermediaries (including administrative fees net of expenses from the government); and
g. Number of employees on the Carrier's payroll on December 31st of the preceding year, including the number of full-time employees whose nor-mal work week is 30 or more hours, but not including any employee who works on a part-time, temporary, or substitute basis.
14. Detailed miscellaneous expenses, including, but not limited to, all collection and bank service charges, printing and office supplies not allocated elsewhere, post-age, and telephone not allocated elsewhere.
15. Capital Expenses and Depreciation:
a. Depreciation, including all costs associated with depreciation for elec-tronic data processing, equipment, software, and occupancy;
b. Capital acquisitions, including all expenditures for the acquisition of cap-ital assets, including lease payments that were paid or incurred during the calendar year;
c. Capital costs on behalf of a clinic, including all expenditures for capital and lease payments incurred or paid during the calendar year on behalf of a clinic (or part of a partnership, joint venture, integration, or affiliation agreement); and
d. Other capital costs, including expenditures for other costs that are directly associated with the incurring of capital costs, such as legal or administra-tive costs, incurred or paid during the calendar year.
16. Net income, which equals direct premiums earned, less direct Claims incurred, less expenses, plus investment gains and losses.
(c) Balance Sheet
1. Accumulated surplus, including common stock, preferred stock, gross paid in and contributed surplus, surplus notes, unassigned funds, and other capital or surplus items.
2. Accumulated reserves, including all reserves, including Claim reserves, premium reserves, and contract reserves.
3. Risk based capital ratio, as derived in accordance with 211 CMR 25.00.

(4) The company will provide a detailed description of any method of allocation employed to at-tribute expenses that are not directly assigned to a group size or line of business, and the ex-penses, group sizes, and lines of business to which the allocation is applied.

(5) If a Carrier is unable to provide any of the required information in its Annual Comprehensive Financial Statement, the Carrier shall provide a detailed explanation, within the Annual Com-prehensive Financial Statement, of the reason(s) that such required information is not available.

(6) A Carrier that fails to submit its Annual Comprehensive Financial Statement to the Division on or before April 1 of each year shall be assessed a late penalty by the Commissioner not to exceed $100.00 per day.

(7) The Division shall make public all of the information collected under this section. The Division shall issue an annual summary report of the annual comprehensive financial statements to the joint committee on financial services, the joint committee on health care financing, and the house

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Comment: The template used for public disclosure should have the most critical info at the "top-lines" of the form, including MLR, Members Covered, and Lives Covered, so that "value" is readily apparent to consumers and legislators.

and senate committees on ways and means. The information shall be exchanged with the center for health information and analysis for use under section 10 of chapter 12C. The Division shall, from time to time, require Carriers to submit the underlying data used in their calculations for audit.

156.08: Audit of Annual Comprehensive Financial Statement

(1) The Commissioner may, in his or her discretion, require that a Carrier make available the underlying data used in its calculations for its Annual Comprehensive Financial Statement, if applicable, for audit by Division staff or outside consultants or advisors of the Division.

(2) Any and all fees and costs for the Division's audit of the Carrier's Annual Comprehensive Financial Statement shall be borne by the subject Carrier.

156.09: Public Hearing on Carrier's Financial Condition

(1) If, in any year, a Carrier reports in its Annual Comprehensive Financial Statement that its Risk-Based Capital ratio on a combined entity (entity-wide) basis (Such as a holding company system with more than one type of license; companies that have risk sharing and reinsurance contracts across corporate entities; etc), exceeds 700%, then the Commissioner, or a designated Presiding Officer, shall hold a public hearing to examine the Carrier's overall financial condition and the Carrier's continued need for additional surplus.

Comment: The term "combined entity basis" should be clarified or defined. The term used in MGL 176X is "entity wide," and should also be used here.

(2) The public hearing shall be held within 60 days of the date of the Carrier's filing of its fully completed Annual Comprehensive Financial Statement.

(3) At the public hearing, the Carrier shall submit testimony on its overall financial condition and its continued need for additional surplus. The Carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the Carrier will dedicate any additional surplus to reducing the cost of Dental Benefit Plans, or on dental Quality Improvement Activities, patient safety, or dental cost containment activities not conducted in previous years.

(4) The Commissioner shall issue written notice of the public hearing to the subject Carrier no less than 30 days prior to the public hearing.

(5) The Carrier shall arrange for newspaper publication of the written notice of the public hearing in a newspaper or newspapers designated by the Commissioner. Such notice shall be published no less than 21 days prior to the public hearing.

(6) No later than 15 days prior to the public hearing, the Carrier shall submit a filing to the Division containing:

(a) The title and docket number of the proceeding and the complete name and address of the Carrier submitting the filing;

(b) A summary containing a description of the contents of the filing;

(c) A list of the names and occupations of all persons who will present oral testimony, statements, or comments on behalf of the Carrier at the public hearing; and

(d) Any other information required by the Commissioner or the Presiding Officer.

(7) The Carrier's filing shall describe the Carrier's overall financial condition and the reasons why the Carrier believes the additional surplus is needed. The filing shall also describe how, and in what proportion to the total surplus accumulated, the Carrier will dedicate any additional surplus to reducing the cost of Dental Benefit Plans, or on Dental Care Quality Improvement Activities, patient safety, or dental cost containment activities not conducted in previous years.

(8) Duties of the Presiding Officer. The Presiding Officer shall conduct the public hearing and take appropriate action to ensure the orderly conduct of the public hearing. Testimony may be taken under oath or affirmation, at the discretion of the Presiding Officer.

(8) Transcript. The Carrier shall arrange that any public hearing be officially recorded by a stenographer. The full cost of the stenographer's fees, along with the cost of providing two copies of the written transcript of the public hearing to the Division, shall be paid by the Carrier.

(9) The Commissioner shall review the testimony from the public hearing and issue a final report on the public hearing.

156.10: Severability

If any section or portion of a section of 211 CMR 156.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 156.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.