March 10, 2025

RE: House Bill 1481 – OPPOSE

Dear Chairman Lee and committee members,

On behalf of the American Council of Life Insurers (ACLI)[1], we appreciate the opportunity to provide comments in opposition to House Bill 1481. As introduced, this bill would create a dental minimum loss ratio (MLR) of 75 percent for dental benefit plans. This bill would create unintended consequences that severely impact access to dental care and benefits for North Dakotans. It would lead to increased premiums, reduced use and access to dental services, and a reduction in employer and consumer options for purchasing dental coverage.

Dental Plans Differ from Medical Plans

Dental plans offer a wide variety of products and benefit designs compared with medical plans. Any measurement of a dental plan's value must reflect the fundamental differences between how medical and dental plans are structured, priced, offered, and purchased if it is to be accurate and meaningful to consumers.

Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventive services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Consumers share a higher percentage of the cost for restorative procedures such as crowns, periodontal surgery, and dentures. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5 percent.

In North Dakota, dental premiums are on average, about $33 per month[2] and medical premiums are, on average, about $708 per month.[3] At a 75 percent loss ratio, this leaves medical plans with over $175 to cover administrative expenses per member per month. At a 75 percent loss ratio, dental plans would be left with less than $9 to cover administrative expenses per member per month. This small amount would not cover the cost of basic plan operations for even the most cost-efficient plans: administration; claims systems; compliance; and state-mandated consumer protections and commissions. If low-cost plans

[1] ACLI is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long- term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] NADP, 2024. Dental Benefits Report. (link)

[3] "Average Annual Singel Premium per Enrolled Employee for Employer-Based Health Insurance," Kaiser Family Foundation (2023). Employers typically contribute about $613 per month while employees typically contribute about $95 per month.

cannot cover their administrative expenses under the 75 percent loss ratio, those plans may be forced to no longer offer in North Dakota or to raise premiums to cover increased costs.

In Massachusetts, the only state to adopt a similar, mandatory dental loss ratio (through ballot initiative), the market for dental insurance has contracted significantly, with at least 7 fewer carriers in the small group and individual markets, a 32 percent decline, since the imposition of the DLR in 2022. An independent analysis of similar bills indicates that a mandated dental loss ratio of 75 percent could raise premiums for dental coverage by 114 percent for small groups, and 78 percent for the individual market.[4] The analysis highlighted the risk that such a sudden and rapid increase in the cost of coverage will lead many small businesses to forgo dental plans for their employees and reduce access to oral health care.

Dental Plans and Oral Health

House Bill 1481 has the potential to dramatically reduce the availability of dental coverage in North Dakota with negative effects on access to oral health care. Dental coverage is closely linked to the regular utilization of preventive dental care, which is critical to avoiding acute oral health issues and pain. Under a typical dental plan, preventive care is covered at 100 percent cost sharing to incentivize utilization and a regular relationship with a dentist. Regular preventive dental care and cleanings have also been shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions.

Dental insurance has been shown to be highly price sensitive and an increase in premiums may lead to a reduction in dental coverage. Losing coverage often means patients must pay full list price for their dental care and a cleaning may cost hundreds of dollars out of pocket. As a result, many people without dental coverage skip regular preventive services to reduce costs and in the long term this increases their likelihood of developing more serious dental problems. Just one missed cleaning makes a patient more likely to develop cavities, plaque, and periodontal conditions. For these reasons, we oppose House Bill 1481 and urge you not to advance the legislation.

National Council of Insurance Legislators ("NCOIL") Model

In 2023, NCOIL adopted the Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act ("NCOIL Model") that would promote transparency and protect the current dental insurance market. The Model Act is a result of a compromise between the American Dental Association and the National Association of Dental Plans. The NCOIL Model would achieve the goals of House Bill 1481 without the unintended consequences of higher costs to consumers and market constriction.

The NCOIL Model requires dental insurers to report MLRs to the Department of Insurance. The commissioner would then calculate an average for each market segment: individual, small group, and large group and investigate any insurers who fall far enough outside the average. Commissioners would have authority to remediate the insurers where appropriate and potentially establish an MLR based on the average if an insurer falls outside the average for two consecutive years. It would also allow flexibility for the experts at the Department of Insurance to determine if there is a legitimate reason that the MLR is low, for example a plan in its first year that must build up reserves.

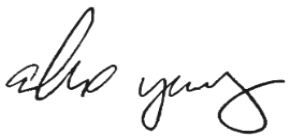
[4] AB 2028 Medical Loss Ratios Report final to Legislature 04122024.pdf

Enacting the NCOIL Model would allow the commissioner to set an MLR appropriate for the market when a plan falls outside the market average for two consecutive years. This approach protects consumers by preventing the market disruption we are seeing in Massachusetts. Rather than setting an arbitrary number across all market segments without fully assessing what the market can withstand, the NCOIL Model relies on the expertise of the Department of Insurance to assess the market and intervene where appropriate.

Under the NCOIL Model, insurers would be held to greater standards of transparency and would be held accountable for inappropriately low MLRs. However, there is unlikely to be the rise in costs we would see if insurers had to meet a 75 percent MLR that is too high for the market to support. Consumers would benefit from the transparency and accountability, but would not be subject to rising costs and less choice in plans.

Thank you for your consideration. We look forward to working with you to develop this alternative avenue to evaluate the value of dental benefits in North Dakota.

Respectfully submitted,



Alex Young
Legislative Director, State Relations
ACLI

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act

Sponsored by Del. Steve Westfall (WV)
Co-sponsored by Rep. Rita Mayfield (IL)

Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on January 26, 2024. To be placed on the Executive Committee's agenda for final ratification at the 2024 NCOIL Spring Meeting on April 14, 2024.

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Section 1. Title

This Act shall be known and cited as the "[State] Medical Loss Ratios for Dental (DLR) Health Care Services Plans Act."

Section 2. Purpose

The purpose of this Act is to provide for transparency of the expenditure of dental health care plan premiums, and to require annual reports and remediation if the dental loss ratio falls below a certain percentage.

Section 3. Definitions

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Dental carrier" or "carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

(c) "Dental health care service plan" or "plan" means any plan that provides coverage for dental health care services to enrollees in exchange for premiums, and does not include plans under Medicaid or CHIP.

(d) "Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated pursuant to subsection (i) in this section.

(i) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

(A) The numerator is the sum of the amount incurred for clinical dental services provided to enrollees, the amount incurred on activities that improve dental care quality, and other incurred claims as defined at 45 CFR 158.140(a); and

(B) The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community expenditures as defined at 45 CFR 158.162(c), and any other payments required by federal law.

(1)(a) The Commissioner shall define by rule:

(I) expenditures for clinical dental services;

(II) activities that improve dental care quality;

1. Activities conducted by an issuer intended to improve dental care quality shall not exceed five percent of net premium revenue

(III) overhead and administrative cost expenditures; and

(ii) The definitions promulgated by rule pursuant to this Section must be consistent with similar definitions that are used for the reporting of medical loss ratios by carriers offering health benefit plans in the state. Overhead and administrative costs must not be included in the numerator.

Section 4. Transparency of Patient Premium Expenditures

(a) A carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Dental Loss Ratio (DLR) annual report with the Commissioner that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The filing must also report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

(b) The DLR reporting year shall be for the fiscal year during which dental coverage is provided by the plan. All terms used in the DLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If data verification of the carrier's representations in the DLR annual report is deemed necessary, the commissioner shall provide the carrier with a notification 30 days to submit any information required by the Commissioner.

(d) By January 1 of the year after the Commissioner receives the dental loss ratio information collected pursuant to subsection (a) of this Section, the Commissioner shall make the information, including the aggregate dental loss ratio and other data reported pursuant to this Section, available to the public in a searchable format on a public website that allows members of the public to compare dental loss ratios among carriers by plan type by:

(i) Posting the information on the division's website; or

(ii) Providing the information to the administrator of an all-payer health claims database. If the Commissioner provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the Commissioner.

(e) The Commissioner shall report the data in this Section to the Legislature.

Section 5. Excess Revenue and Rebate

(a) The Commissioner shall aggregate dental loss ratios for each carrier by year pursuant to Section 4 for each market segment in which the carrier operates. The commissioner shall calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period including data for the most recent dental loss ratio reporting year and the data for the two prior dental loss ratio reporting years.

(1) Newer experience shall be subject to reporting standards at 45 CFR 158.121

(b) The Commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection 5(a), identify as outliers dental plans that fall outside 1 standard deviations of the average dental loss ratio, and report those plans to the legislature consistent with the manner set forth in subsections 4(e) and 4(d) above.

(1) A carrier shall not be considered an outlier if its DLR in a market segment is within 3 percentage points of the average dental loss ratio. A higher threshold may be set in unique circumstances as determined reasonable by the commissioner.

(c) The Commissioner shall investigate those carriers that report a DLR lower than 1 standard deviations from the mathematical average, and may take remediation or enforcement actions against them, including ordering such carriers to rebate, in a manner consistent with 45 C.F.R. Part 158(B) of the ACA all premiums paid above such amounts that would have caused said carrier to have achieved the mathematical average of the data submitted in a given year for a given market segment.

(d) The report in subsection (b) shall be organized to show year-over-year changes in a carrier's outlier status relative to meeting the 1 standard deviation outlier standard at subsection (b). If the DLR for a carrier in a market segment does not increase and remains an outlier as defined in subsection (b) after 2 consecutive years, barring unique circumstances as determined reasonable by the commissioner, the carrier shall be subject to a minimum DLR percentage by market segment. The commissioner shall promulgate rules establishing the DLR percentage based on, at minimum, the average of existing carrier loss ratios by market segment in the state to be effective no sooner than 42 months after a carrier is determined to be an outlier as defined in this section.

(e) A carrier subject to remediation in subsections (c) and (d) shall provide any rebate owing to a policyholder no later than xxxxx of the fiscal year following the year for which the ratio described in subsection (a) of this section was calculated. The Commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

(f) The Commissioner may promulgate rules that create a process to identify carriers that increase rates in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.

Section 6. Rules

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act.

Section 7. Effective Date

This Act shall take effect xxxxxxx.