August 2, 2021

The Honorable Brendan P. Crighton, Senate Chair
The Honorable James M. Murphy, House Chair
Joint Committee on Financial Services
Massachusetts State House
Boston, MA 02133

Re: Opposition to H.1171/S.714, S.631/H.1181, H.1182/S.632, H.1173/S.236, and H.322

Dear Chairman Crighton and Chairman Murphy:

We are a coalition of trade associations, whose members offer dental coverage, writing to express our strong opposition to H.1171/S.714, S.631/H.1181, H.1182/S.632, H.1173/S.236, and H.322. The National Association of Dental Plans (NADP) is the representative and recognized resource of the dental benefits industry. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. The Life Insurance Association of Massachusetts (LIAM) is a trade association that represents 23 of the nation's leading life, long term care, disability, and dental insurance carriers. LIAM members also offer family and medical leave and retirement plans. These dental insurance bills seek to increase dentists' reimbursement and impose additional regulatory burdens on dental plans at the expense of Massachusetts consumers. None of these measures will provide meaningful rights or benefits to dental consumers. Rather, they will unnecessarily increase costs for dental plans, leading to higher premiums and restricted access to care for Massachusetts constituents.

Assignment of Benefits

H.1171/S.714, S.631/H.1181 threaten to undermine the effectiveness of insurance products by allowing the assignment of benefits and mandating reimbursement rates. By allowing the assignment of benefits, dental plans would be forced to pay nonparticipating providers directly at the same rate as a participating provider, rather than reimbursing the plan member. Additionally, these bills state that a member would only be able to assign benefit payments to a nonparticipating dentist when they meet the credentialing criteria of the dental plan. The provider credentialing process is a detailed and thorough process which is an essential consumer protection. It includes the verification of both primary and secondary sources of critical data related to the individual provider (e.g. licensure, education, malpractice history, work history, etc.). In order for a provider to be included in the network, the provider must pass through these crucial quality checks. Our concern is that, because nonparticipating providers are under no obligation to comply with a dental plan's credentialing criteria, there will be no way for members to determine whether the nonparticipating provider meets them. Dental plans utilize provider networks as an important tool to improve quality and to control oral health care costs though contractual discounted fee reimbursements, which these bills would severely disrupt. These proposals

dramatically reduce providers' incentives to join networks, erode existing networks at significant increased cost-sharing for consumers whose dentist is now out-of-network, and would cause significant disruption within the dental insurance marketplace surrounding network recruitment, and provider reimbursement, all of which would lead to premium increases for a very price sensitive product.

Medical Loss Ratio

H.1182/S.632 imposes unnecessary reporting requirements, including a medical loss ratio reporting for dental insurance, that are administratively costly and provide little value to Massachusetts consumers. The Massachusetts Division of Insurance (DOI) once required loss ratio reporting for dental plans but repealed that requirement in 2017 because it was of little benefit to them. Likewise, the financial reporting requirements proposed in the bills were once imposed on dental plans but quickly repealed by the General Court when it was shown that they were burdensome to dental plans and provided little useful data. The financial reporting requirements proposed in the bill were later repealed for all carriers, including major medical plans, in 2018. Dental plans continue to file detailed financial reports with the DOI to examine plans' financial solvency and overall value provided to enrollees. Dental loss ratios are significantly lower than medical ratios. Dental premiums are 1/20th of medical premiums while dental plans and medical issuers perform the same basic administrative functions with similar structures (e.g., claim payment, customer service, network development, anti-fraud, etc.). Dental plans have far fewer premium dollars to support similar administrative functions, which are critically important. They are also subject to taxes and fees similar to health plans. For these reasons, it is reasonable to expect lower minimum loss ratios for dental insurance than for medical. Loss ratios should be considered in their original context: Medical plans were assigned minimum loss ratios in the ACA due to that Act's mandate that all individuals *must* purchase (or be provided by an employer) an ACA-compliant health plan. Health plans accepted these loss ratios because they were assured significant enrollment increases. However, pediatric dental is the only required essential health benefit. For most Americans, dental coverage remains optional. Dental plans agree that the focus should be providing consumers great value for their dental plans. Dental loss ratios are not a useful or meaningful measure of a dental plan's value to consumers; dental policies should be evaluated in dollars, not in percentages.

Dental Patient Bill of Rights

We have multiple concerns about the Dental Patient Bill of Rights bills (H.1173/S.236). In addition to the adverse assignment of benefits provisions that make plans pay non-participating providers the same rate as participating providers already described above, H.1173/S.236 requires redundant explanation of benefits (EOB) through a website. Plans already provide EOBs to both the provider and patient, with the patient getting the info they need in the mail, rather than having to seek it out on their own. The overpayment section limits the dental plan's ability to collect a payment issued to the provider for a service not rendered. Providers are sent multiple requests for refunds prior to funds being deducted from a future claim. Furthermore, these bills need more detail on the predetermination language, which are explicitly not prior authorizations. A predetermination is an optional process that members and providers can voluntarily request, in real time via a web portal, information about benefit coverage and payment to help make an informed decision about dental treatment and costs. As written, the language does not consider the non-binding nature of predeterminations. As a result, carriers would have to honor predetermination information regardless of changing circumstances for a patient or related to fraud, waste, and abuse. The provisions of H.1173/S.236 would ultimately force dental plans to raise premiums and consumer costs, and likely discontinue providing predeterminations entirely.

Direct Dental Care Agreements

While H.322 does not change dental plan practices, we do have concerns that these direct dental care agreements could be harmful to consumers. The bill allows for subscription-based dental coverage, described as "Netflix for your teeth." Under this service, dentists offer in-house coverage for dental procedures. The bill establishes that these agreements shall have no oversight from the DOI. We caution that by offering these subscription plans, dentists may legally become risk bearing organizations which *must* be regulated by the DOI pursuant to 211 CMR 155. Our concerns also include the lack of basic consumer protections without any direct regulatory oversight, including the potential for high pressure sales tactics, failure of members to understand the scope of their coverage, and lack of recourse for grievances or right to appeal.

Dental plans deliver value at low and stable premiums. Nationally over the last 8 years, the dental benefits industry has had negative premium growth in some years and the highest positive yearly change was only 2.5% compared to medical premiums increasing every year. Over 5.5 million, or 82%, Massachusetts residents have dental coverage, more so than the national average. In Massachusetts, 44% of consumers covered by dental benefits have an annual household income of less than $50,000. Rather than creating pathways to affordable care, these bills actually create financial barriers to accessing dental care in the Commonwealth. This will no doubt be detrimental to both the dental and physical health of families and individuals in Massachusetts. For these reasons, we oppose H.1171/S.714, S.631/H.1181, H.1182/S.632, H.1173/S.236, and H.322 urge you to give them an unfavorable report. Thank you for your consideration

Sincerely,

Teresa Cagnolatti	Bernard Peppard	Camile Simpson	Jenny Erickson
Director of Government & Regulatory Affairs	Regional Director State Affairs	Regional Vice President State Relations	General Counsel
NADP	AHIP	ACLI	LIAM