ISSUE BRIEF

Medical Loss Ratio (MLR) Requirements for Dental Plans

The passage of the 2022 ballot referendum (Question 2) in Massachusetts established a minimum loss ratio for dental plans based on the loss ratio of medical plans, which earn 20x the premium. Since then, many states have considered legislation related to reporting or establishing loss ratios for limited-scope dental plans.

Background

Medical plans vs. dental plans

Medical and dental plans differ significantly in their structure of premiums and coverage. Medical plans have higher premiums due to their wide scope and coverage of expensive services like surgeries, hospital stays, and advanced diagnostics. They also often have high deductibles and out-of-pocket maximums. Dental plans, in contrast, have lower premiums, reflecting the predictable, lower-cost nature of routine dental care such as exams, cleanings, fillings, and basic restorations. Dental plans feature simpler benefit designs with annual maximums and a focus on preventive services which are often covered at no cost to the consumer. Despite these structural differences, both dental and medical plans share administrative responsibilities such as claims processing, call center staffing, network management and fraud prevention.

The Affordable Care Act and Medical Loss Ratio

The ACA's medical loss ratio (MLR) mandate is part of a broader framework that provides billions of dollars to medical plans to stabilize the post-ACA medical insurance market. This framework includes individual/employer mandates to purchase coverage, risk corridors to cover early losses, and reinsurance to help cover high risk individuals and subsidies to make coverage more affordable.

The Affordable Care Act (ACA) introduced a comprehensive formula for determining the MLR of medical plans:

Claims + Quality Improvement Expenses + Fraud Prevention Activities / Premiums + Credibility Adjustment

Under the ACA, medical plans must meet an 80% MLR for individual and small group markets, and 85% for large group markets. Medical plans must submit annual MLR reports to demonstrate compliance. If they fail to meet these thresholds, they are required to provide rebates to policyholders. This mechanism was created to ensure a substantial portion of premiums is spent directly on medical care and quality improvement rather than administrative costs and profits. This was part of the ACA's broader effort to improve healthcare accessibility.

However, dental insurance lacks the comprehensive regulatory framework found in the ACA. There are no equivalent risk corridors, reinsurance programs, or subsidies designed to stabilize the market or reduce consumer costs.

It is noteworthy that Congress intentionally omitted dental benefits from the Affordable Care Act's loss ratio provisions because MLRs do not capture or communicate the value of low-premium insurance products like dental plans.

Dental insurance premiums have remained affordable without mandates, with average increases of around one percent per year. While medical plan premiums have generally risen about 5 percent yearly over the last decade, dental premiums have only risen 1 or 2 percent yearly. In addition, most dental plans cover 100% of preventive services with no out-of-pocket costs. These trends demonstrate that dental benefits have remained valuable and cost-effective.

The dental insurance market features considerable competition and stable premiums—neither of which were common in state medical insurance markets when the ACA created a national mandate for medical insurance. Profit margins in dental insurance are in keeping with other low premium insurance products. The problems that MLR supposedly ameliorates for medical insurance do not exist in dental insurance.

Impacts of High Loss Ratio Requirements

A low-premium dental plan (premiums about $35 a month) cannot achieve the same loss ratio as a high-premium medical plan (premiums commonly close to $700 a month). Low-premium insurance products—dental or otherwise—cannot achieve the same loss ratio as high-premium products because many administrative costs are fixed or semi-fixed, irrespective of premium. For example, a seven-minute member call costs the same amount, whether it concerns a $80 teeth cleaning or a $55,000 heart bypass surgery. A claim costs the same amount to process whether it concerns a dental bite-wing x-ray (about $50) or an MRI (commonly more than $2,000). Low premium dental products will always have lower loss ratios because of the differences in scope of coverages and expense in services previously described.

The two ways to achieve a higher MLR are to 1) reduce administrative costs and 2) increase payments. Administrative costs include many services that are necessary to plan operations and good consumer experience. These include:

- Paying claims
- Operating call centers
- Responding to consumer inquiries
- Enrolling new members
- Adjudicating appeals
- Ongoing credentialing and re-credentialing of providers and network maintenance
- Investigating allegations of fraud
- Investing in new technologies
- Complying with regulations

Each of the services listed can be delivered at varying levels. To raise their MLR percentage, dental plans may be forced to lower administrative costs by reducing the quality or availability of these services.

The results may include longer wait times to speak to a live representative, smaller networks, and claim processing delays. Reductions in these services will negatively impact the way that consumers and providers interact with their dental plans.

In addition to reducing administrative costs, dental plans can raise the MLR by increasing payments to providers. However, increased cost of care ultimately drives up premiums and cost-sharing for consumers, as seen with higher-cost medical insurance.

While dental plans can reduce administrative costs or increase provider reimbursements to raise their MLR, these changes upset the balance between affordability and access. Dental plans cannot meet the high MLR expected of medical plans without ultimately impacting both consumers and providers.

Insights from CHBRP

The California Health Benefits Review Program (CHBRP) was formed in 2002 to respond to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. In April 2024, the California State Legislature commissioned a CHBRP study during consideration of AB 2028, a proposed MLR bill on dental benefits. AB 2028 proposed an 85% MLR on dental benefits in the state.

CHBRP considered the implications of an arbitrarily high loss ratio and projects that huge premium increases would be necessary in most of the state's insurance markets to comply with the loss ratio requirement. Specifically, CHBRP states that:

DHMO plans would need to raise premiums by 215% in the individual market, 266% in the small group market, and 145% in the large group market.

DPPO plans would need to raise premiums by 78% in the individual market, 114% in the small group market, and 13% in the large group market.

CHBRP notes, "Some individuals may no longer purchase the higher-priced policies, and some groups may discontinue offering dental or pass the costs on to enrollees; as a result, some people may face significantly higher out-of-pocket costs with delayed dental preventive care. This may result in poorer population-level oral health."

State Activity and the NCOIL Model

State regulations play a critical role in defining MLR standards for dental plans. Historically, some states have had prospective loss ratio requirements through the rate filing process. These ratios are generally lower than medical, according to the guidance of the National Association of Insurance Commissioners (NAIC) on low-premium products. A few states have specific MLR requirements for retrospective review of dental insurance, while others employ a report and remediation approach.

State Highlights

For example, in 2014 California passed AB 1962, which requires annual reporting by market and product type. This data is made publicly available and used by the legislature to consider adoption of a medical loss ratio for health care service plans and health insurers that cover dental services. California elected not to move forward with implementing a dental loss ratio.

In 2022, Maine passed LD 1266, a loss ratio reporting bill requiring outlier identification and remediation. Loss ratio is calculated over a three-year period by market segment and posted for public consumption. This law empowers the commissioner to identify outliers that are greater than two standard deviations from the market segment average and seek a remediation plan, including but not limited to rate revisions or benefit modifications.

In 2023, Colorado passed SB 23-179, a similar loss ratio bill to Maine, requiring annual reporting, public posting, outlier identification and remediation. However, Colorado took it a step further requiring the submission of additional data, including number of enrollees, cost sharing and deductible amounts, annual maximums, and number of enrollees meeting or exceeding the annual max to better understand the state of their market.

Three states passed dental MLR laws in 2024. Virginia HB 1132 now requires dental plans to report their loss ratios annually. Louisiana's law, SB 463, is also reporting-only; dental plans must report financial data organized by market and plan type, including a cap on activities to improve dental quality.

Rhode Island's new law requires MLR reporting and asks the state's insurance commissioner to consider whether a MLR requirement is necessary.

Massachusetts' Approach

The passage of Question 2 ballot referendum in Massachusetts represented a substantial shift in how loss ratio was considered for dental plans, as it not only established an arbitrary threshold but also applied requirements not previously applied to dental plans. Question 2 requires the reporting of current and projected loss ratio, administrative expenses, and other financial information to the Department of Insurance annually. Question 2 sets the dental loss at 83%, requiring rebating to covered individuals and groups if the threshold is not met.

Additional requirements include annual rate and financial statement filing. The annual rate filing provision of Question 2 allows for the disapproval of rates deemed excessive, inadequate, or unreasonable in relation to the benefit charge. The commissioner is given the authority to presumptively reject these filings and hold a public hearing.

As a result of the complexity of these requirements and the rule-making process, significant delays were seen in the implementation of the Massachusetts MLR requirements effective on January 1, 2024.
In 2024, NADP commissioned NORC to conduct a study on the impact of the Massachusetts MLR. The National Opinion Research Center (NORC) at the University of Chicago is an independent research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions.

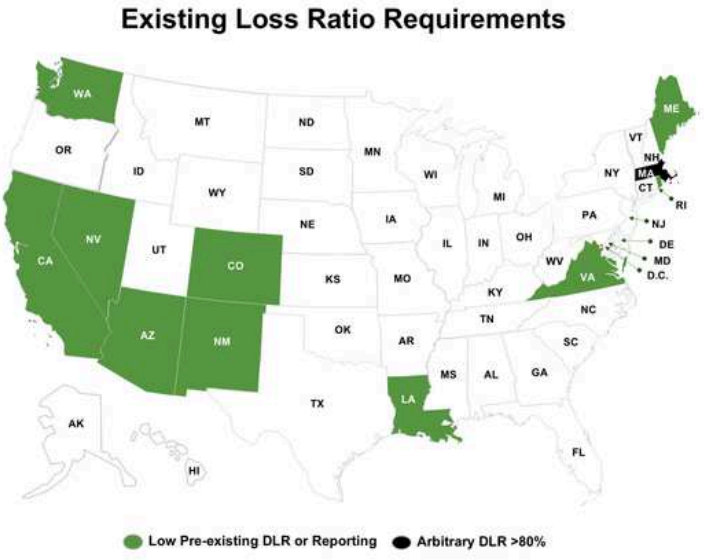
The NORC study reveals the following:

Figure / data from "Early Impacts of the Minimum Medical Loss Ratio for Dental Plans in Massachusetts: Perspectives of Dental Plans and Dental Brokers, Spring 2024" by NORC at the University of Chicago, August 2024.

The delay in Massachusetts regulations enforcing the MLR created market uncertainty. The NORC study concludes, "Many of our findings in Massachusetts mirror those predicted by CHBRP's analysis of California Assembly Bill 2028's potential impact. This includes withdrawal of plans from specific markets, disruption to the individual and small group market, and reduced commissions to dental insurance brokers."

As a result of these strict requirements and market uncertainty, Massachusetts has seen the exit of eight dental insurers from the marketplace, resulting in disruptions in care and less consumer choice.

Following the passage of Massachusetts Question 2, more than a dozen states have considered the application of loss ratio to dental plans in their legislatures, including bills mirroring or modeled after the Massachusetts initiative. However, no state has passed a bill establishing a medical-level loss ratio like that of Massachusetts. Instead, states have looked to alternative options to increase transparency, recognizing that a one-size-fits-all approach does not meet the needs of their markets or consumers. The Massachusetts law is still new and its full impacts are not apparent, but we already know that seven dental plans withdrew from one or more insurance markets. Many plans substantially cut the commissions paid to brokers for getting employers to offer dental insurance to their employees. More impacts are likely in 2026 and beyond.



NCOIL Model

Recognizing the growing interest in the application of loss ratios to dental plans, the National Council of Insurance Legislators (NCOIL) proposed a dental loss ratio model law. After much consultation with dental plans and providers, NCOIL adopted the "Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act" in April of 2024. The model law is based on the Colorado reporting and outlier structure.

The NCOIL model act and recent state trends may have significant implications for the dental benefits industry:

- Increased Regulatory Oversight: The passage of these laws indicates a trend toward greater regulatory scrutiny in the dental benefits market.
- Increased Administrative and Compliance Costs: The adoption of the NCOIL model law based on the Colorado framework could encourage more states to implement similar legislation, leading to a more standardized approach to regulating dental insurance across the country. However, this could also increase compliance costs and administrative burdens.
- Increased Transparency: The passage of loss ratio reporting laws could increase understanding of dental insurance premiums and finance mechanisms, providing consumers greater transparency of the dental insurance market.

Conclusion

Dental and medical plans have similar administrative costs but dramatically different premiums. Low-premium dental and other ancillary benefit plans were specifically excluded from the MLR requirements under the Affordable Care Act. An attempt to align medical and dental plans through an arbitrarily high MLR for dental insurance will not help consumers or providers. As demonstrated by the CHBRP analysis, premiums will increase significantly, leading to higher costs for consumers, a reduction in dental office visits, and fewer people with coverage.

It is improbable that applying MLR to dental plans will deliver the public any benefit, but for policy makers interested in pursuing regulation, the pathway forward should reflect the stepwise approach adopted by multiple state legislatures and recognized in the in NCOIL model, rather than the rash approach taken in Massachusetts.