ADA American Dental Association®

1111 14th Street, N.W.
Suite 1200
Washington, DC 20005

T 202.898.2400
F 202.898.2437
www.ada.org

July 14, 2025

The Honorable Asw. Pamela Hunter, President NCOIL
The Honorable Sen. Paul Utke, Vice President NCOIL
William Melofchik, CEO, NCOIL
National Council of Insurance Legislators
616 Fifth Avenue, #106
Belmar, NJ 07719

Dear Asw. Hunter, Sen. Utke, and Mr. Melofchik:

The American Dental Association values its longstanding relationship with the National Council of Insurance Legislators (NCOIL) which has led to several foundational dental insurance reform policy models that have demonstratively benefitted dental patients throughout the country.

We are writing to inform you that the ADA has revised its policy on dental loss ratio (DLR) at its 2024 House of Delegates meeting, and, that we intend to seek changes to NCOIL's current DLR model that was adopted in 2023 to align with our current policy. The ADA's policy changes are designed to improve payer transparency and ensure consumer premium dollars are being directed to pay for patient care and not company profits. We believe this coincides with one of NCOIL's stated goals which is to '*improve the quality of insurance regulation.*' The ADA's current DLR policy is attached for your review.

In drafting the revised policy, the ADA House of Delegates adopted a list of expenses under an '*include'* and '*exclude'* format. We believe this new policy directive gives greater clarity to legislators, regulators, and the public, to support DLR's intent of a establishing a valid measurement of dental insurers' investment in actual patient-directed dental care.

For example, the ADA's new policy states that *community expenditures* should not be a factor in calculating dental insurers' investment in care to enrolled patients. Insurers and dental professionals are well regarded for providing charitable care in their own capacities, which is laudable. However, this factor should not be involved in the calculus for dental loss ratio, which is designed to unambiguously measure enrollees' value in the dental coverage they purchase. Enrollees do not purchase dental benefits for carriers to divert premium dollars away from enrollees' care no matter how noble. Charitable care expenditures should be viewed as an entirely different concept independent from the DLR measurement of enrollees' value. Allowing charitable community benefit expenditures to impact DLR measurement does nothing more than mask the clear intention of a DLR measurement and allows insurers to dilute the ratio in their favor without any additional investment in enrollees' care.

Further, ADA's revised DLR policy expressly states that *agent and broker fees and commissions* should be explicitly excluded from inclusion in the numerator or should not be permitted to be deducted from the denominator. When these fees, which can vary greatly, are included in the calculus, they cloud the outcome of DLR calculations and reduce the value of DLR as an indication of insurers' true investment in patient care. While additional directives concerning the use of expenditures in determining ratios are listed in the ADA

policy, the aforementioned are among the more egregious expenditures that routinely enter into the DLR calculation. The result is weak public policy that does not compel clear or transparent accountability to enrollees on their valuable premium dollars.

Thank you for the opportunity to share ADA's updated position on dental loss ratio. We value our shared work to improve patient care through insurance policy reform and modernization. It is in that spirit that we wanted to make clear that our current pathway on DLR reform differs from NCOIL's model act. However, we would welcome the opportunity for the NCOIL DLR model to be considered for review ahead of its scheduled 2029 renewal timeframe. This expedited review, will strengthen NCOIL policy and protect consumers in a more effective and transparent manner.

We look forward to continued work with NCOIL.

Sincerely,

Brett Kessler, D.D.S.
President
American Dental Association

Elizabeth Shapiro, D.D.S., J.D.
Interim Executive Director
American Dental Association

Enclosure
cc: Rich Rosato, President-elect, American Dental Association
James Schulz, American Dental Association
Chad Olson, American Dental Association
Anne Kennedy, Gen Counsel, NCOIL
Patrick Gilbert, Director of Policy, Administration & Member Services, NCOIL

ADA American Dental Association®

1111 14th Street, N.W.
Suite 1200
Washington, DC 20005

T 202.898.2400
F 202.898.2437
www.ada.org

Medical (Dental) Loss Ratio (Trans.2015:244; 2019:262; 2024:XXX)

Resolved, that the ADA supports the concept of a "Medical Loss Ratio" for dental plans defined as the proportion of premium revenues that is spent on clinical services, specifically:

(A) The numerator is the sum of

(1) the amount paid for clinical dental services provided to enrollees and

(2) the amount paid to providers on activities that improve oral health through clinical services for plan enrollees.

(B) The denominator is the total amount of premium revenue, excluding only

(1) federal and state taxes,

(2) licensing and regulatory fees paid, and

(3) any other payments required by federal law,

and be it further

Resolved, that states pursuing MLR, refer to the definitions of each of the amounts referenced in the numerator and denominator within the ADA's Glossary of Dental Administrative Terms maintained by the ADA Council on Dental Benefit Programs (CDBP), and be it further

Resolved, that dental plans, both for profit and nonprofit should be required to make information available to the general public and to publicize in their marketing materials to plan purchasers and in written communications to their beneficiaries the percentage of premiums that fund treatment and the percentage of premiums that go to administrative costs, promotion, marketing and profit, or in the case of nonprofit entities, reserves, and be it further

Resolved, that the ADA support legislative efforts to require dental benefit plans to file a comprehensive MLR report annually, which contains the same information required in the 2013 federal MLR Annual Report Form (CMS-10418) along with 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 and to establish a specific loss ratio for dental plans in each state, and be it further

Resolved, that a "specific loss ratio" be calculated by each state as the average dental loss ratio for each market segment (large group and small/individual groups as defined within the state). If the average loss ratio is less than 85% for large group plans and 83% for small/individual groups, then states should aspire to establish a mechanism to have MLR improved to at least this benchmark over time. For those carriers reporting MLR above 85%, such carriers should be required to maintain operations at that level, and be it further

Resolved, that when a carrier fails to meet the MLR, the carrier be required to issue rebates to plan purchasers, and be it further

Resolved, that instituting an MLR should not result in premium rate increases in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.

* ***Glossary of Terms***

Loss Ratio for Dental Plans: the proportion of premium revenues that is spent on clinical services, specifically:

The **numerator** is the sum of (1) the amount paid for clinical dental services provided to enrollees and (2) the amount paid to providers on activities that improve oral health through clinical services for plan enrollees.

The **denominator** is the total amount of premium revenue, excluding only (1) federal and state taxes, (2) licensing and regulatory fees paid, and (3) any other payments required by federal law.

Numerator definitions:

- "Amount paid for clinical dental services" must only include direct claims paid to providers, including under capitation contracts, for clinical services covered by the plan. Amount should not include:
    1. funds withheld from providers for any reason
    2. over payments recovered from providers
    3. any cost-sharing amount paid by the plan enrollee
    4. adjustments recouped pursuant to coordination of benefit policies
    5. payments recovered through fraud reduction efforts
    6. share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans issued by the same carrier
- "Amount spent on oral health improvement activities" must only include activities that are:
    1. directed toward individual enrollees, i.e., plan participants or incurred for the benefit of specified segments of plan enrollees to improve access and outcomes
    2. based on clearly defined, objectively measurable, evidence-based criteria issued by the ADA or nationally recognized healthcare quality organizations
- Expenditures and activities that must not be included are those that:
    1. are designed primarily to control or contain costs
    2. are expenditures towards community benefit or persons not enrolled in the plan
    3. were paid for with grant money or other funding separate from premium revenue
    4. can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services

Denominator definitions:

- "Amount of premium revenue" means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan. Amounts should include any state or federal subsidy.

Overhead administrative cost expenditures that should not be included in the numerator or deducted from the denominator include expenditures related to:

- “Nonprofit community expenditures” means expenditures for activities or programs expended by the carrier for enhancing public health for people who are not beneficiaries of the plan. This includes activities that:
    1. are available broadly to the public, e.g., activities supporting water fluoridation
    2. reduce geographic, financial, or cultural barriers to accessing health services or
    3. advance health care knowledge through education or research that benefits the public
- network development, secondary network savings, administrative fees, claims processing, and utilization management, fraud prevention activities, provider credentialling or marketing expenses regardless of whether these activities are performed by the carrier or outsourced to a third-party vendor
- providers such as consultants, for professional or administrative services that do not represent
- compensation or reimbursement for covered services provided to an enrollee
- establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims
- developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to vendors
- stop-loss or re-insurance costs
- direct sales salaries, workforce salaries and benefits
- agents and brokers fees and commissions
- General and administrative expenses