September 12, 2022

Superintendent Russell Toal
Office of Superintendent of Insurance
PO Box 1689
Santa Fe, New Mexico 87504-1689

Dear Superintendent Toal:

On behalf of the National Association of Dental Plans (NADP)[1], America's Health Insurance Plans (AHIP)[2], and the American Council of Life Insurers (ACLI)[3], we are writing to share our comments regarding the proposed rule "Minimum Standards for Dental and Vision Plans" which amends 13 NMAC 13.10.35. We appreciate that the Office of Superintendent of Insurance (OSI) considered and made changes to the draft proposed rule circulated in June 2022 to stakeholders and look forward to further constructive dialogue. However, NADP, ACLI, and AHIP remain concerned that OSI is contemplating reopening this Regulation, which was originally adopted last year on June 8, 2021, with an effective date of January 1, 2022 ("the 2021 rule"). As set forth below, we believe that the rule does not address or alleviate concerns in New Mexico related to dental access and oral health equity. Instead, it will limit consumer choice and increase costs, significantly impacting access to dental care in New Mexico.

Regulatory Authority (13.10.35.3)

The proposed rule derives its authority from two statutes pertaining to the regulation of the limited-scope excepted benefits plans in New Mexico and one regarding the implementation of New Mexico's state based marketplace, which concerns qualified health plans (QHPs). The statutes pertaining to limited-scope excepted benefits enumerate the explicit scope of the

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

[3] The American Council of Life Insurers (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.

capacity of the Superintendent to regulate such plans. We are concerned that the scope of the proposed rule may expand beyond the intended scope of the authorizing statutes, moving beyond the legislative intent of the authors. While OSI previously stated the intent of the loss ratio section of the proposed rule was to meet requirements of N. M. S. A. 1978, § 59A-23G-5 which governs rules to establish standards for excepted benefits, the statute does not require an MLR to be developed. Instead, it broadly defines means for the department to establish standards for rates that are "based on generally recognized and current actuarial standards." The addition of an MLR requirement to the 2021 rule was discussed during a workshop with OSI and industry stakeholders on January 14, 2021 but was not included in the proposed version of the 2021 rule.

Effective Date (13.10.35.5)

The timeline of implementation for the proposed rule would cause significant difficulties for dental and vision carriers in New Mexico. Implementation of a new major rule on dental and vision coverage less than a year after the 2021 rule risks creating significant confusion and administrative burden that may restrict the capacity of plans to offer in the state. Furthermore, while plans continue to adjust to the requirements of the previous rule, the long-term implications of the 2021 rule are not yet known. Comprehensive analysis of the impact of the 2021 rule would require multiple years of data to establish validity. Plans are continuing to adapt to the requirements of the previous rule, which required plan revisions and alterations in several states as a result of the extraterritorial requirements on the 2021 rule. Any changes in requirements for dental plans should not begin until **January 1, 2025** in order to allow adequate time for adjustment as a result of the substantive changes proposed by this rule.

The intended effects of the proposed changes to the dental minimum standards are not immediately clear. Some of the provisions and requirements of the proposed rule have not been implemented for dental plans in any other state and could have unintended consequences on the dental benefits marketplace that are not yet known. The 2021 rule was a substantive change to the requirements for dental plans in New Mexico, and a second change to a major rule in only one year is an unusual revision without sufficient evidence that the proposed rule will significantly improve dental access.

Extraterritoriality (13.10.35.2)
We believe this regulation's scope should extend only to policies issued within New Mexico. When carriers design benefits, the plans are often multi-state and encompass populations from several areas that are organized into a group to ensure adequate risk prevention and in turn low premiums. By establishing:

"Subject to the foregoing, this rule applies to a group dental or vision plan offered or sold to a New Mexico resident under a master policy delivered outside of this state." (p.1)

The proposed rule threatens to disrupt the business of insurance for multi-state plans and raise premiums. In effect, the minimum standards that OSI seeks to create for New Mexico residents, with the needs of New Mexico in mind, would be applied to other states with vastly different oral health needs. Any change, particularly one that would dictate that plans across multiple states comply to standards designed for New Mexico residents, could lead to higher premiums, lower dental benefits enrollment, and in turn lower oral health outcomes. We propose the below revision to the section:

> **13.10.35.2 SCOPE:** This rule applies to every carrier who offers or sells any individual or group dental or vision insurance plan ("plan") separately from a health benefits plan, whether on or off the exchange. This rule does not apply to any pediatric dental or vision plan, or to any prepaid dental plan. Subject to the foregoing, this rule applies to a group dental or vision plan ~~offered or sold to a New Mexico resident under a master policy delivered outside of this state.~~ situsedin the state of New Mexico.

Prior Authorization (13.10.35.15 F)
Prior authorizations are rare in dental treatment, with a limited scope of coverage compared to medical coverage which covers a wide range of interacting providers and facilities which interact with the plan. Currently, no other state requires prior authorization for claims denial for dental plans. New Mexico statute defines medical necessity broadly:

"health care services determined by a provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

> (a) any applicable generally accepted principles and practices of good medical care;
> (b) practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
>
> (c) any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease."[4]

This standard encompasses many types of medical decisions, some of which have clear and well-established standards for coverage and treatment. To prevent claims denial without prior authorization on almost all dental procedures would be a significant departure from the current structure of dental care and coverage. In dental, pre-treatment estimates, which are acknowledged in the 2021 rule[5], are utilized to develop a treatment plan with a patient. For

[4] NM Admin. Code 13.10.29.7
[5] NM Admin. Code 13.10.35.15(B)

example, a patient needing multiple root canals could consult with their dentist on a timeline for care based on their dental needs. The dentist in turn could submit a pretreatment estimate to the patient's insurance plan to determine the coverage and medical necessity standards of their coverage. This healthy engagement through a pretreatment estimate allows a patient to receive care covered by their plan and develop a thorough care plan for the dentist.

Dental plans reserve the capacity to deny claims that they deem not medically necessary, particularly if the dentist performs additional cosmetic treatment not covered by the plan. Plans develop significant safeguards for patients to preserve their oral health and limit waste, fraud, and abuse, and retain resources for providers on the scope and coverage of their plans. If dental plans were not able deny claims without a prior authorization, they would likely begin to require prior authorizations on most basic and extensive dental treatments. This would significantly expand the administrative requirements for dental providers and plans, slowing the treatment plans of patients and increasing overall spending. Today, many medical providers report that they spend at least 16 hours a week on prior authorizations.[6] In turn premiums and cost of care may increase to meet the expanding administrative costs, feeding a cycle of cost increases that harms access to care and outcomes.

Typically, a dental plan will honor a pretreatment estimate if the underlying care plan does not change. If the patient's oral health condition changes, dentists may find it necessary to develop or modify their care plan and submit a request for a new estimate. In these cases it is beneficial that the estimate is nonbinding, giving the provider the flexibility to modify their care plan for the patient to meet their needs and utilize related dental coverage. Requiring prior authorizations would greatly increase the administrative burden on plans and dentists through this process.

We recommend that OSI alter the proposed requirements to allow plans to elect to require pretreatment estimates for care as they deem necessary, while maintaining the elective and non-binding requirements in statute to retain flexibility for plans and providers based on the needs of a dental patient.

> **B. Pretreatment Estimates:** A carrier may issue a non-binding pretreatment estimate for the coverage and reimbursement of proposed dental or vision services. A pretreatment estimate does not determine medical necessity and does not serve as a prior authorization.
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> (1) A pretreatment estimate shall include a statement that clearly indicates to the covered person that the estimate is not a guarantee of coverage.
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> (2) A pretreatment estimate shall clearly identify the services that require an approved prior authorization for coverage and shall include a statement that the covered person may be liable for the full cost of the service if an approved prior authorization is not obtained.

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[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6140260/#:~:text=Physicians%20and%20their%20staff%20spend%20an%20average%20of%2016.4%20hours,services%20that%20they%20may%20need.

(3) A dental plan may require a pretreatment estimate of any covered dental service.

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~~**F. Prior-authorization.** If a plan does not require prior authorization, policy document must clearly state that the plan shall not subsequently deny claims on the basis of medical necessity.~~

Dental Medical Loss Ratio (13.10.35.9 F-N)

Dental plans in New Mexico and across the nation want consumers and employers to know what they are buying and what is covered. NADP, AHIP, ACLI, and New Mexico dental benefits carriers agree that the focus should be providing consumers greater value for their dental plans; however, **MLRs are not a useful or meaningful measure of a dental plan's value to consumers or employers who purchase dental plans, and the proposed MLR measurement is unworkable.**

Extraterritoriality and the Proposed MLR

In every other state with prospective MLR requirements for health or dental products, the reporting and calculation are determined for plans sitused in the state. By requiring the calculation of the MLR to include all plans with New Mexico residents, the proposed rule significantly complicates the ability of dental plans to estimate their costs for reporting. For example, in a dental plan that contains 80% enrollees outside of New Mexico also comprised of 20% New Mexico residents, a reported MLR of the entire plan is not an accurate estimation of administrative costs utilized by New Mexico residents, or the value of their coverage.

Utilization and access also vary widely between states and regions, further complicating any information that could be used to derive a statement of value based on an extraterritorial MLR requirement. Furthermore, states that do not currently require an MLR requirement for dental products but contain enrollees in the same dental plans as New Mexico residents would be required to meet the New Mexico standard. These states may have significantly different insurance marketplaces from New Mexico and the implementation of an MLR for dental plans operating in their state and New Mexico could harm dental access by limiting dental plan availability.

Therefore, any MLR requirement established by New Mexico should state that its requirements apply to plans that are domiciled within the state, allowing for a uniform data collection and reporting process.

Medical Loss Ratio Applicability to Dental

An MLR is a ratio of expenditures to insurance premiums. A loss ratio does not measure value. A loss ratio measures the cost of covered patient care (to a dental plan) divided by the total premium charged. High minimum ratios can be achieved either through a large numerator (high dental expenditures) or through a small denominator (low insurance premiums). Low MLR dental plans, by definition, spend a higher percentage of premium on administration; this is not, however, inherently bad for consumers. It is not clear that lower administrative expenses are socially more desirable than higher expenses, given that higher administrative expenditures may reflect a greater investment in management of care. Furthermore, neither premiums nor expenditures by themselves indicate quality of care. Patient satisfaction surveys, preventive services use, and clinical outcomes can all shed light on quality of care; a loss ratio does not.

Dental plans often provide value to consumers by investing a portion of premiums in developing stronger networks with deeper discounts, delivering patient protections against fraud and abuse, educating and incentivizing consumers to use their benefits more efficiently, or by providing sophisticated web tools, online provider directories and pre-treatment cost estimators that increase transparency. Dental plans must budget for such activities with a much smaller premium than medical, thereby resulting in a lower MLR.

The range of premiums and benefit designs in the dental benefits market makes it impossible to compare dental plans using MLR data. Patients in lower MLR, lower-cost managed care dental plans can receive more patient care than patients in some higher MLR, high-cost dental plans. A low MLR plan can be more affordable to more consumers, especially those least likely to have premiums subsidized by an employer, and can provide greater out-of-pocket savings to consumers. Conversely, higher loss ratios do not translate into more dental care or better oral health. High MLR plans can be less affordable for individuals and small groups, who are more likely to defer their dental care needs.

Consumers can arguably receive greater “value” from a lower MLR plan; however, this will not be reflected using a metric that only puts the cost of patient care to the plan in the numerator, and its premium in the denominator. As dental carriers’ blocks of business decrease in size, their loss ratios also trend downward, this is due to higher administrative costs per member due to lack of scale. Similarly, loss ratios are lower on individual than group dental business due to the higher administrative expense allocation to individual business. This means that smaller dental carriers, particularly those specializing in individual coverage, will be affected to a greater extent than larger carriers by the minimum dental loss ratio set under the proposed rule.

Imposing a static loss ratio requirement across all dental benefit programs discourages a diversity of products as well as investment in those administrative systems that promote effective utilization of the benefits, encourage transparency, and protect patients from fraud and abuse. Applying loss ratios to dental policies requires carriers to reduce expenses and/or increase

payments to providers thus increasing premiums for consumers. The higher payments to providers add little value to the consumer in relation to the increase in premiums. MLR proposals were discussed during the public comment and consultation process of the 2021 rule, with stakeholders raising similar concerns at that time. As a result, the 2021 rule did not include an MLR requirement for dental or vision plans.

If New Mexico intends to finalize a medical loss ratio requirement, we proposed the following changes to the rule to better capture how dental plans utilize incurred premiums for the benefit of enrollees:

13.10.35.7 DEFINITIONS: For definitions of terms contained in this rule, refer to 13.10.29 NMAC, unless otherwise noted below.

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D.“Loss ratio” means the earned premiums divided by incurred claims, calculated pursuant to Subsection D of 13.10.35.9 NMAC.

E. Activities that improve dental care quality. The superintendent shall define "activities that improve dental care quality" to include but not limited to services such as case management; oral health assessments; identifying and addressing ethnic, cultural or racial disparities in effectiveness of best clinical practices and evidence-based medicine; quality reporting; and health information technology

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS:

I. Calculating the loss ratio for individual and group dental and vision plans. The loss ratio is calculated as the ratio of the numerator and the denominator, as defined in Paragraphs (1) and (2) below. The loss ratio shall be calculated separately for dental and vision coverages, even if both dental and vision benefits are included in a single policy or contract.

(1) Numerator. The numerator is equal to:

(a) the incurred claims for the loss ratio reporting year;

(b) The amount spent on activities that improve dental care quality for the loss ratio reporting year;

(c) the amount of claims payments identified through fraud reduction efforts; for the loss ratio reporting year;

(2) Denominator. The denominator is the earned premiums for the loss ratio reporting year, excluding federal and state taxes and licensing and regulatory fees paid and after accounting for any payments pursuant to federal law.

M. Disclosure and reporting compliance with minimum loss ratio requirements.

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over the last three calendar years of experience and for each calendar year of experience utilized in the rate determination process, but never less than the last three years. The initial measurement period shall be the years, 2025, 2026 and 2027. Each year thereafter, the subsequent year shall be added to the rolling three-year period and the oldest year shall be removed. For example, the second measurement period shall be 2026, 2027 and 2028.

(4) Frequency. Loss ratios shall be calculated annually by carriers that issue vision or dental plans specified in this rule, beginning with the 2023~~3~~5 reporting year.'

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(9) Corrective action plan. The superintendent may require a corrective action plan ~~to return excess premiums or increase benefits~~ if the minimum loss ratio requirements are not met over the measurement period.

Insurance Cards (13.10.35.13 D)

Requirements for dental plans to provide information and schedules of benefits should clarify that plans may offer resources physically or electronically. In a typical dental care setting, a covered individual is not required to utilize an ID card to receive treatment. The information is usually accessible through a plan portal, app, or website if needed, alongside additional resources which can explain benefits or direct an individual to a help line.

INSURANCE CARDS: Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or electronic insurance cards, which may be available within the carrier's member portal, or, in the alternative, on an electronic or physical separate wallet-sized card , which may also be available within the carrier's member portal, that is issued simultaneously with the health insurance card.

13.10.35.8 General Prohibited Policy Provisions

NADP, ACLI, and AHIP members seek clarification of the intent of this section which appears to require plans to enumerate "any exclusion" that "remove[s] coverage for a benefit or loss that would otherwise be covered under the terms of the policy." Administratively, exclusions may be used in a wide variety of circumstances to indicate payment for care. For example, "missed appointment" is listed as an exclusion and it is explained in the insurance certificate that a plan will not pay benefits for any charges incurred for a missed appointment. Based on this provision however, if a plan can only "list exclusions that remove coverage for a benefit or loss that would otherwise be covered under the terms of the policy," a plan would not be allowed to include "missed appointments" on the list of exclusions. If this was the case, it would be misleading and confusing to covered individuals. We recommend OSI strike provision (5) from 13.10.35.8.C or clarify the intent of the provision for further discussion.

NADP, ACLI, and AHIP appreciate the opportunity to comment on the proposed rule. We strongly urge OSI to reconsider elements of the proposed rule creating extraterritorial MLR requirements and increased administrative burden through prior authorization requirements. These requirements could substantially harm the dental benefits market and oral health access in New Mexico.

Thank you again for your attention to this important matter. We are available to answer questions or provide additional information.

Sincerely,

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National Association of Dental Plans

Karlee Tebutt
America's Health Insurance Plans

Cindy Goff
American Council of Life Insurers