Dentistry Responds to the American Dental Association's "Compromise" on the National Conference of Insurance Legislators Dental Loss Ratio Plan

By: Michael W. Davis, DDS **3-24-2024**

The dental insurance industry and National Association of Dental Plans (NADP) has widely celebrated their victory over the American Dental Association (ADA) related to a compromise agreement on dental loss ratios.[1,2] In fact, the NADP spiked the ball after their triumph.[3]

"NADP appreciates NCOIL's (National Association of Insurance Legislators) leadership in achieving this compromise model legislation for loss ratios. The result is proof that when acting in good faith with the ADA, that two organizations with different views can reach a reasonable compromise," remarked NADP Executive Director Mike Adelberg.

The ADA's negotiation was largely held in secret from ADA membership and the ADA's elected House of Delegates. The principally empty plan (Model) disregarded the content of the dental loss ratio (DLR) statute passed in Massachusetts which applies to all dental insurers and not just a handful of outlier insurance plans. The Massachusetts Model also sets a hard figure on DLR at 83%, and limits exclusions such as nonprofit community expenditures.

Dr. Mouhab Rizkallah, author of Massachusetts Question 2 offered, "The worst loophole in the ADA-NADP compromise is the agreed-to definition of Dental Loss Ratio, which allows insurers to subtract nonprofit community expenditures from their total premium revenue (the DLR denominator)."[2]

"You will be shocked to know that in 2019, Delta Dental of Massachusetts contributed $291 Million dollars to their own non-profit affiliate (Catalyst Institute), while only paying $177 Million that same year for patient care. In 2018, they moved $327 Million to Catalyst Institute. Massachusetts Question 2 stops this from recurring." said Rizkallah.

Rizkallah added that today (in Massachusetts) charitable contributions cannot be subtracted from total premiums, because the voter initiative defined all charitable contributions as administrative costs of the Insurer. Without this provision, DLR becomes meaningless. A more detailed overview of Rizkallah's views on DLR protections for the public may be seen on this referenced YouTube video.[4]

Texas Dentists for Medicaid Reform[2] listed problematic issues with the negotiated compromise Model:

1. **Roving DLR:** The model legislation's approach to identifying and remedying outliers through a "roving DLR" based on average market ratios is problematic. This methodology could potentially allow insurers to maintain strategies that minimize spending on patient care, as long as they remain within a fluctuating benchmark that doesn't necessarily incentivize improvements in patient care spending.

This is problematic for the ADA as the agreement violates the ADA House of Delegates policy requiring a "specific loss ratio" for dental plans.

2. **Nonprofit Community Expenditures and Quality Improvement Activities**: The exclusion of "nonprofit community expenditures" and broad definitions of "Quality Improvement Activities" from the DLR calculation might provide insurers with a loophole to divert funds in ways that do not directly benefit patient care, potentially inflating the DLR and undermining the framework's transparency objectives.

3. **Broker Commissions**: The handling of broker commissions within the DLR calculation also raises eyebrows. By allowing these commissions to be excluded from the premium revenue used to calculate the DLR, there's a risk that the true proportion of premiums spent on patient care could be misrepresented, offering insurers a pathway to meet regulatory thresholds without genuinely increasing patient care investments.

The NCOIL by contrast stated that this agreed upon model *"…*will provide guidance to states seeking to pass legislation related to dental loss ratios."[5]

The NCOIL Model is sponsored by West Virgina Delegate Steve Westfall and co-sponsored by Illinois Representative Rita Mayfield. Westfall said, "I am proud to sponsor this Model as it will ultimately help ensure that dental insurance is affordable and available to consumers."

Westfall continued, "While it took over a year for NCOIL to reach a consensus, I am thrilled that we landed on a version of the Model that the Committee and representatives from both sides (ADA vs. NADP) could support. I thank the Committee for its patience in listening to and incorporating input from a wide variety of perspectives and I look forward to passing a bill based on this Model in West Virginia and seeing other states do the same."

Today it seems reasonable to ask if the NCOIL Model agreed upon by the ADA represents not so much of a ***compromise***, but arguably a ***capitulation***. Some contend a non-transparent faction of ADA leadership insiders may have conducted such capitulation.

To help answer that question, Dr. Bob “Dee” Dokhanchi, founder of *Dentistry in General* first interviewed a panel consisting of Dr. Raymond Cohlmia, Executive Director of the ADA, Dr. Marko Vujicic, ADA Chief Economist and Vice President of the ADA’s Health Policy Institute, Dr. David Leader, ADA Member and Associate Professor Tuft’s University, and Dr. Mouhab Rizkallah, author of Massachusetts Question 2.[7]

Later, related to the ADA NCOIL Model compromise, Dokhanchi interviewed a panel inclusive of Dr. Linda Edgar, ADA President, Dr. Randall Markarian, ADA Trustee, Mr. Mike Graham, Senior VP for ADA Government and Public Affairs, and Mr. Chad Olsen, ADA Director for State Governmental Affairs (and former employee of Delta Dental).[8] A range of questions were proffered to the group.

Dokhanchi respectfully inquired why top insurance industry negotiators with a positive record, like Rizkallah and Massachusetts Dental Society President Dr. Abe Abdul, were excluded from the ADA’s negotiation team or even consultation. Panelists were queried why the compromise Model omitted the significant reforms to benefit patients, which are in the Massachusetts’ statute on DLRs. Dokhanchi also raised the matter on the apparent lack of transparency to ADA Membership and the ADA House of Delegates with the negotiations.

Edgar opined that the NCOIL compromise was only a baseline starting point. She added that the voter initiative process (as in Massachusetts) is far different than the circuitous and tortuous procedure to get a bill through a state legislature. As to concessions with those having a history of negotiation lacking good faith, Edgar said, “If you’re not at the table, you’re probably on the menu.”

Obviously from their press releases and in contrast to Edgar, neither the state legislators under NCOIL, nor dental insurers as represented by the NADP view the compromise Model as a “starting point.”

Oklahoma

The Oklahoma Dental Association (ODA) has been the first component dental society to openly express their disapproval with the NCOIL Model.[9] (This open letter from ODA President and ADA Delegate Dr. Paul Wood and Dr. Lindsay Smith, Chair for the ODA Counsel on Governmental Affairs, to Edgar and Cohlmia will be reprinted at the conclusion of this report.)

The ODA expressed their displeasure on how the ADA accepting a compromise related to DLR legislation has blown up their legislative progress. “The NCOIL model legislation includes a dental loss ratio calculation that is difficult to understand and certainly difficult to explain to lawmakers.”

“The NCOIL Committee passed the model legislation on a Friday, and by the following Monday morning, dental benefits company lobbyists were in every Oklahoma House and Senate Insurance Committee members’ office peddling the NCOIL model. We had not seen the legislation, so it was impossible to comment when we were contacted by legislators that morning. And the fact that the dental benefits companies were pushing it so hard gave us pause, which gave out bill author pause, as well, resulting in our difficult decision to pull our bill from legislative consideration.”

“(in bold letters) **As a direct result of the ADA’s action in this matter, we had to make the difficult decision to discontinue our efforts to establish a dental loss ratio for our patients this year.”**

The ODA’s letter went on to address concerns over the ADA’s lack of transparency in the negotiation process through appropriate channels of elected constituent and component membership.

Wood and Smith concluded, “The Oklahoma Dental Association views this decision as a monumental failure of our governing structure and an abuse of executive power within our association. As stated previously, a decision of this magnitude that will impact over 160,000 ADA members should not be made by a select few staff members and the President.”

Interestingly, Cohlmia formerly served as President of the ODA and in many leadership positions at both the state and component district level. He was also the former dean at the Oklahoma University College of Dentistry.

One may well imagine that the letter delivered to Cohlmia and Edgar was not easily prepared. Wood and Smith’s letter was not created in a vacuum. The entire leadership of the ODA must have participated in the process. Considerations to the interests of the dental profession and the public welfare took precedent over personal and professional friendships. True leadership making difficult calls was apparently on display.

Massachusetts

The Massachusetts Dental Society (MDS) Board of Trustees issued an open letter to the ADA Board of Trustees on March 22, 2024. The MDS took exception to substantive points in the NCOIL compromise model.[10]

Three specific areas of include:

1. The term "Nonprofit Community Expenditures" in Section 3(d)(i)(B)3 creates a known loophole - which allows insurers to redirect patient care funds to their own affiliated non-for profit companies. This pattern of contribution is allowed by the Section 3 terms of the NCOIL DLR-framework, and these funds would be exempt from the DLR reporting - leading to an inflated DLR calculation.
2. The term "Quality Improvement Activity" (QIA) is another known financial loophole in the NCOIL framework,5 which allows non-claims expenses to be counted in the DLR numerator (as if they were patients claims paid). QIA's have been the subject of significant litigation and abuse by medical insurers in the past decade. Dental insurers argued for this loophole during the Massachusetts Question 2 DLR hearings. However, Massachusetts draft regulations restricted the language at 45 CFR 158.150, closing the loophole with the following protective language: "Quality Improvement Activity (QIA). An activity designed to improve dental quality that is performed equitably by or through a provider to all patients, requires clinical expertise, increases the clinical wellness and promotion of health activities, produces clinical outcomes that can be objectively measured and can produce verifiable results, be directed toward individual Members of a Carrier's plans or segments of Members, as well as populations other than Members (as long as no additional costs are incurred for the non-Members, and as long as the activity can be supported by evidence-based medicine, best clinical practices, or supported by criteria issued by professional dental associations that meets all the requirements of 45 C.F.R 158.150(b)). A QIA may include disease management, case management, and other dental management expenses. A QIA does not include any activities that are identified under 45 C.F.R. 158.150(c), that have any overlap with administrative expense items specified under M.G.L. c. 176X, § 2(b)(i)-(x), that have any marketing component that displays the name of the Carrier, or that are paid for by the Carrier to any affiliate of the Carrier in any way, either directly or indirectly." (emphasis provided)
3. While the term broker "commissions" must be reported as an administrative expense according to 45 CFR Part 150, the Center of Medicaid Services (CMS) provides an exemption to reporting 45 CFR Part 150 DLR commissions. The effect of the CMS exemption is that insurer can hide commissions.

The MDS contends the reporting section of the NCOIL DLR-Framework is misleading and meaningless.

1. Deflated Denominator: (by excluding Premium Revenue)

a. "Non-Profit Community Expenditures" are excluded from the denominator, while funds are "contributed" to non-profit affiliates - falsely Inflating the DLR.

b. "Commissions" are excluded from the denominator, even though patients are paying the broker through their premium payment - falsely Inflating the DLR

2. Inflated Numerator: (by including Non-Claims Expenses)

a. "Quality Improvement Activities" (QIA) are freely added to the numerator up to 5% - falsely inflating the DLR Reporting

The MDS desires to reverse the insurance industry strategy of making more money by spending less on patient care, to making more money by spending more on patient care.

Dr. Abe Abdul, President of the MSD offered a statement. He wants to make certain his words are received as strictly his own viewpoints and do not represent the MDS. “The NCOIL agreement, as currently drafted, allows insurance companies to decrease their DLR each year while ostensibly adhering to all regulations. In essence, it fosters a competitive race towards diminishing standards—a race to the bottom."

Dr. Jill Ann Tanzi, a Hopkinton, Massachusetts practicing general dentist and Director with the Alliance of Independent Dentists spoke out, “I believe the NCOIL agreement undermines the progress we have made in Massachusetts with the passing of a DLR. This agreement sets a bad precedent for the other states in that it will not truly reform dental plans. Unfortunately, this is a huge loss for consumers.”

The Alliance of Independent Dentists is a national group of dentists (initially founded in Massachusetts) advocating and educating the public on why independently owned and operated dental practices are superior to corporate dentistry, how the insurance industry undermines the doctor/patient relationship, and whistleblowing and promoting legislation to protect and serve the public interest.[11]

New Mexico

New Mexico has a nearly meaningless mandated DLR of 65% and the accounting exclusions make the statute a virtual sham.[12]

Executive Director of the New Mexico Dental Association Dr. Tom Schripsema last week issued an email letter to membership in support of the ADA’s compromise position. Schripsema contends the ADA NCOIL model “is an acquiescence by the insurance industry to hold themselves more accountable to those that are covered by their plans.”

“The NCOIL legislation takes a different approach to establishing a benchmark MLR (DLR) from the ballot measure in Massachusetts and legislation in several other states. Instead of

establishing an immediate loss ratio, it forces the MLR to gradually increase over time. It does this by requiring dental plans that chronically under-perform to meet an MLR at the level of the mean. As more companies are required to meet an MLR at the mean, the level of under-performance that triggers a mandatory MLR becomes less. At the same time, the reporting requirement increases the transparency which makes it easier for plan purchasers to choose plans with a higher MLR. If companies raise their MLR to remain competitive, the mean for all plans will rise, which consistently raises the bar for the under-performers."

"I would urge everyone to take some time understanding the NCOIL model legislation before concluding that it was a bad deal for the ADA. I'm sure that the ADA will support states as they pursue whatever model they think can be successfully adopted in their state, but now there is also a choice of a model which legislators may find more palatable, and insurers will find difficult to oppose."

Schripsema concluded, "Keep in mind that it was the tortoise that won the race, not the hare."

Interviewed for this report, Schripsema stated, "I certainly understand people's frustration and that it complicated things for a few states with legislation pending, but the ADA didn't have a lot of choice. It was either this or nothing and it was almost nothing."

"This was not a negotiation between the payers and the ADA. It was a negotiation with the NCOIL sponsor. Had they (ADA negotiators) not agreed to this there was a chance that NCOIL would have come out against MLR reform completely or complicated the pending legislation in other ways." added Schripsema.

Schripsema concluded, "My suspicion is that some states will get what they want in spite of the NCOIL model because it is too complicated for them (legislators) to understand. Again, there is more than one way to win out of this."

Conclusion

Passage of Question 2 in Massachusetts represents a significant disruptor to the dental insurance industry, as well as the dental profession. Patients and plan purchasers (employers) demand more transparency and value related to their dental insurance decisions. The days of the dental insurance industry tossing a few bones out in payments are in transformation.

Doctors who formerly could not compete with the insurance lobby impacting their state legislators, today are making significant progress to assist their patients' welfare. For now, headway is slow and tedious. That will change.

Further, leadership in organized dentistry would be wise to embrace full transparency, especially with membership. Advancement with insurance industry reform will not progress so much from the top down, but by contrast the bottom up. Egos should not trump favorable outcomes benefiting the public interest, as feathers get ruffled.

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Please scroll down to access letter from ODA leadership to ADA leadership.

Oklahoma Dental Association

March 1, 2024

Drs. Linda Edgar, President and Raymond Cohlmia, Executive Director
American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611

Drs Edgar and Cohlmia,

On behalf of the Oklahoma Dental Association Board of Trustees and Council on Governmental Affairs, we are writing to inform you of our opposition to and disappointment in the ADA's recent decision to sign-on to the Health Insurance and Long Term Care Issues Committee of the National Council of Insurance Legislators (NCOIL) model legislation for a dental loss ratio.

We came close to establishing a dental loss ratio in Oklahoma in 2023. Our bill passed the Oklahoma House of Representatives unanimously and was ultimately defeated in the Senate Insurance and Retirement Committee on a 5-5 tie vote. With that momentum, we spent the rest of 2023 working hard to educate legislators about the value to Oklahoma patients in establishing a dental loss ratio and felt confident that our 2024 bill was going to prove successful.

Our bill had a much stronger definition of dental loss ratio, including a specific list of what could and could not be included in the calculation, rather than relying on the Affordable Care Act formula that was the basis for the national medical loss ratio. Our 2024 bill would also have set a specific percentage requirement for large and small dental benefits companies to maintain, specific reporting requirements, and a requirement for dental benefits companies to issue rebates to premium payers when loss ratios were not met. It was easy to understand, easy to explain and easy to enforce. The NCOIL model legislation includes a dental loss ratio calculation that is difficult to understand and certainly difficult to explain to lawmakers.

The NCOIL Committee passed the model legislation on a Friday, and by the following Monday morning, dental benefits company lobbyists were in every Oklahoma House and Senate Insurance Committee members' office peddling the NCOIL model. We had not seen the legislation, so it was impossible to provide comment when we were contacted by legislators that morning. And the fact that the dental benefits companies were pushing it so hard certainly gave us pause, which gave our bill author pause, as well, resulting in our difficult decision to pull our bill from legislative consideration.

Once we finally had a chance to review the model legislation, we learned the NCOIL model does not go near far enough in protecting our patients from unwanted dental benefits company intrusion. It is inferior to our legislation in many ways. And the timing of the adopted model language made it impossible for us to use the model legislation as "the floor," and impossible for us to be "free to pursue our own ceilings by adding provisions and ratio percentages that meet the needs of our community." **As a direct result of the ADA's action in this matter, we had to make the difficult decision to discontinue our efforts to establish a dental loss ratio for our patients this year.**

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Further, after contacting several of our colleagues on the ADA Board of Trustees and Council on Government Affairs, we learned that neither group had an opportunity to debate and vote on this decision prior to the ADA signing on. As sitting Delegates to the ADA House, we are deeply concerned and frustrated. A decision of this magnitude, which has a profound impact on a Constituent's ability to advocate for our membership and our patients, at the very least, MUST include debate and consensus of an ADA Council or Board of Trustees. The Oklahoma Dental Association views this decision as a monumental failure of our governing structure and an abuse of executive power within our association. As stated previously, a decision of this magnitude that will impact over 160,000 ADA members should not be made by a select few staff members and the President.

Respectfully submitted,

Paul Wood, DDS
ODA President

Lindsay Smith, DDS
Chair, ODA Council on Governmental Affairs

cc: ADA Board of Trustees; Dr. Leigh Kent, Chair, ADA Council on Governmental Affairs; Dr. David Hildebrandt, 12th District representative to the ADA Council on Governmental Affairs