Resolution No. 517 New

Report: N/A Date Submitted: [Date Submitted]

Submitted By: Dr. Spencer Bloom, delegate, Illinois

Reference Committee: D (Legislative, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time: Amount On-going:

ADA Strategic Forecast Outcome: Public Profession: Increase and improve dental coverage and access.

AMENDMENT TO ADA POLICY ON MEDICAL (DENTAL) LOSS RATIO TO STRENGHTEN IT

Background: In October 2024, the ADA House of Delegates adopted Resolution 306H-2024, establishing official ADA policy on dental loss ratios (DLR). That policy eliminated loopholes that enabled exaggerated DLR ratios through broker fees, charitable contributions, and non-clinical Quality Improvement Activities (QIA).

While 306H-2024 was an excellent stop-gap measure, experience since the adoption of 306H-2024 has revealed the need for more refinement. For example, while the 306H-2024 policy defines benchmarks of 85 percent for large group plans and 83 percent for small/individual plans, it does not clearly state whether those benchmarks apply to each insurance **plan** or to the **market-wide average of all plans.** Clarification is needed.

This resolution is intended to refine details in the policy on Medical (Dental) Loss Ratio (*Trans*.2015:244, 2019:262, 2024:XXX) so that it contains a clear framework for future negotiations with external organizations. History has shown (e.g., Rhode Island & Nevada) that NCOIL model definitions and implementation are cited by insurers as a reason to reject better reforms modeled after Massachusetts Question 2. ADA policy must, therefore, be clear and detailed.

In July 2025, pursuant to HOD policy 306H-2024, the ADA sent a letter to NCOIL stating the ADA must revisit the NCOIL DLR Model Legislation ahead of schedule because the ADA had passed a policy resolution incompatible with the NCOIL DLR model. While that letter was focused on the definitions for calculating the dental loss ratio, the critical implementation mechanism was not addressed. For this reason, 306H-2024 must add detail related to DLR mechanism.

Massachusetts' approach remains the most robust model to date (2022, Ch. 287) and includes all core elements, and sets an enforceable plan-level threshold for tangible dental insurance reform. This resolution amends 306H-2024 to close remaining implementation gaps and establishes negotiation principles to guide any future ADA engagement with external parties on dental loss ratio policy.

Resolution

Resolved, that the policy titled "Medical (Dental) Loss Ratio" (*Trans*.2015:244; 2019:262; 2024:XXX) be amended as follows (additions underlined, deletions ~~stricken through~~):

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 the ADA shall adopt the following principles as negotiation framework for any future development, negotiation, endorsement, or support of model dental loss ratio legislation in collaboration with external organizations:

1. Loss ratio benchmarks must apply to individual insured dental plans (not to market-wide averages), and implementation models such as "Rising Tide," which apply only to statistical outliers or rely on multi-year rolling averages, shall be considered non-compliant with ADA policy.

2. Loss ratio targets shall be set at a minimum of 85% for large group plans and 83% for small or individual plans, and insurers whose plans fail to meet these thresholds must issue rebates or premium credits to purchasers. Such rebates must be returned within a defined timeframe, with the return method (check or credit) clearly disclosed.

3. Loss ratio calculations must exclude charitable contributions, broker commissions, and non-clinical quality improvement programs from any part of the numerator or denominator.

4. Insurers must submit publicly accessible annual financial statements, broken down by line of business and plan, and itemized to show spending on direct patient care, administrative expenses, broker fees, charitable giving, and surplus.

5. Insurers with excessive surplus (e.g., a risk-based capital ratio above 700%) must be subject to public financial review and required to explain the need for the excessive surplus, or how the excessive surplus will be reassigned to refund patients or benefit patients.

6. Annual administrative cost increases must be limited to the percentage increase in the dental services Consumer Price Index (CPI), and any rate filings that exceed this threshold may be presumptively disapproved by state regulators, followed by hearings to justify the need for increases above the dental services CPI.

7. State regulatory agencies must retain full authority to disapprove rate filings that are excessive, inadequate, discriminatory, or not actuarially justified, and shall do so within a clearly defined public review timeline with a right to appeal.

8. States should establish mechanisms to improve plan-level loss ratios to meet or exceed the applicable 85% or 83% benchmarks over a defined period of time.

and be it further

Resolved, that the ADA shall develop and distribute model statutory language and implementation guidance for use by state dental societies seeking to strengthen existing dental loss ratio laws or correct previous legislative compromises that do not align with ADA policy as amended, 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.