DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Regulation 4-2-99

DENTAL LOSS RATIO REPORTING REQUIREMENTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-109, 10-1-109(1) and 10-16-165, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish reporting requirements for carriers offering dental coverage plans to report dental loss ratios.

Section 3 Applicability

This regulation applies to all carriers, which includes prepaid dental care plan organizations, offering dental coverage plans.

Section 4 Definitions

A. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. “Community benefit expenditure” shall have the same meaning as found at § 10-16-165(1)(a), C.R.S.

C. “Dental coverage plan” shall have the same meaning as found at § 10-16-165(1)(b), C.R.S.

D. “Dental plan” means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

E. “Dental loss ratio” or “DLR” shall have the same meaning as found at § 10-16-165(1)(c), C.R.S.

F. “Market segment” means, for the purposes of this regulation, the individual, small group, or large group market.

G. “Prepaid dental care plan organization” shall have the same meaning as found at § 10-16-102 (53), C.R.S.

H. “Product(s)” means, for the purposes of this regulation, a discrete package of dental coverage benefits that are offered using a particular product network type (such as dental health maintenance organization, preferred provider organization, exclusive provider organization, etc.) within a service area.

Section 5 Expenditures for Clinical Dental Services

A. Clinical dental care services shall mean, for the purposes of this regulation, diagnostic, preventive, or corrective procedures provided by any oral health care provider, including but not limited to dentists, dental therapists, hygienists, and assistants in the practice of their profession, including treatment of the teeth and associated structures of the oral cavity and treatment for disease, injury, or impairment that may affect the oral or general health of the enrollee.

B. Expenditures for clinical dental care services shall mean claims incurred, including claims incurred but have not yet been reported, by a carrier offering dental coverage plans for clinical dental care services provided to enrollees, and payments under capitation contracts with dental providers whose services are covered by the contract. Expenditures for clinical dental care services shall not include the following:

1. Activities that improve dental care quality as defined in Section 6(A).

2. Overhead and administrative cost expenditures as defined in Section 7.

3. Activities that are nonprofit community benefit expenditures as defined in Section 8.

Section 6 Activities that Improve Dental Care Quality

A. Activities that improve dental care quality include activities conducted by a carrier offering dental coverage plans to improve quality that meet the following requirements:

1. Improve oral and overall health and advance oral health quality, including increasing the likelihood of desired outcomes compared to a baseline; reducing dental disparities among specified populations; and improving patient safety, reducing medical errors, or lowering infection in ways that are capable of being objectively measured and of producing verifiable results and achievements;

2. Directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide oral health improvements to the population beyond those enrolled in coverage as long as no credit is taken for additional costs incurred due to the non-enrollees; and

3. Grounded in the implementation, development, or improvement of evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional dental associations, accreditation bodies, government agencies or other nationally recognized dental care quality organizations.

B. Activities that improve dental care quality shall not include:

1. Activities relating to lines of business or products other than dental, including the pro rata share of expenditures relating to both dental and non-dental business;

2. Activities paid for with grant money or other funding separate from premium revenue;

3. Activities that can be billed or allocated by a provider for care delivery and are reimbursed as clinical dental services;

4. Taxes and assessments;

5. Fines and penalties of regulatory authorities, and fees for examinations by any State or Federal Departments; or

6. Any marketing component that displays the name of the carrier, or that is paid for by the carrier to any affiliate of the carrier in any way, either directly or indirectly.

Section 7 Overhead and Administrative Cost Expenditures

A. Overhead expenditures shall include the following:

1. Rent;

2. Legal fees and expenses;

3. Professional consulting fees;

4. Travel expenditures; and

5. Utility expenditures.

B. Administrative cost expenditures shall include the following:

1. Activities designed primarily to control or contain costs;

2. Establishing or maintaining a claims adjudication system, including upgrades in information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims;

3. Retrospective and concurrent utilization review, and any prospective utilization review that cannot be specifically justified as meeting the definition of “activities that improve dental care quality”;

4. Fraud prevention activities;

5. Developing and executing provider contracts, including establishing or managing a provider network;

6. Provider credentialing;

7. Payroll, except for positions dedicated to activities that improve oral and overall health and the pro rata share of payroll for positions substantially involved in such activities;

8. Marketing expenses;

9. Calculating and administering individual enrollee or employee incentives unless used in the promotion of activities that improve oral and overall health;

10. Direct sales salaries, workforce salaries, and benefits;

11. Agents and brokers fees and commissions; and

12. General and administrative expenses.

Section 8 Nonprofit Community Benefit Expenditures

A. Nonprofit community benefit expenditures shall mean expenditures for activities or programs, or to organizations who administer activities or programs, that seek to achieve the objectives of

improving access to dental care services, enhancing oral health and relief of government burden. This includes any of the following activities that:

1. Are available broadly to the public and serve low-income consumers;

2. Reduce geographic, financial, or cultural barriers to accessing dental services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

3. Address Federal, State or local public health priorities, such as advancing oral health care knowledge through education or research that benefits the public;

4. Leverage or enhance public health department activities; or

5. Otherwise would become the responsibility of government or another tax-exempt organization to the degree the activity serves to improve dental health consistent with this subsection A.

B. Nonprofit community benefit expenditures shall not include overhead or administrative cost expenditures.

C. Nonprofit community benefit expenditures used in dental loss ratio calculations must be reported by type of expense, unless portions of the expense fit under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Payroll expenses included as nonprofit community benefit expenditures, as allowed under Section 7.B.7 of this regulation, should be reported separately by type of expense.

Section 9 Dental Loss Ratio Calculation and Reporting

A. The dental loss ratio shall be calculated for each market segment by dividing the numerator by the denominator, where:

1. The numerator is the sum of:

a. The amount incurred for clinical dental services provided to enrollees;

b. The amount incurred on activities that improve dental care quality; and

c. The amount of claims payments identified through fraud reduction efforts. The amount of claims payments identified through fraud reduction efforts is limited to the lesser of the total fraud reduction expenses or actual fraud recoveries collected on paid claims during the reporting year; and

2. The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures, and any other payments required by federal law. Nonprofit community benefit expenditures are community benefit expenditures made by entities that are exempt from federal income tax. These nonprofit community benefit expenditures included in the denominator must be limited to the highest of either:

a. Three percent of earned premium; or

b. The highest premium tax rate in Colorado, multiplied by the carrier’s earned premium in the applicable Colorado market.

B. A carrier that offers a dental coverage plan shall report the number of covered lives and the data used in the dental loss ratio calculation separately for Colorado and Nationwide market segment experience in the Dental Loss Ratio Reporting template provided in SERFF by the Division.

C. On or before July 31, 2024, and on or before July 31 each year thereafter, a carrier that offers a dental coverage plan shall file a Dental Loss Ratio Reporting template electronically via SERFF with the Division for the preceding calendar year in which dental coverage was provided by the dental coverage plan. Both the calculated dental loss ratio and each data element described in Section 9A of this rule shall be reported for each market segment offered by the carrier.

D. For the initial dental loss ratio report due on or before July 31, 2024, a carrier that offers a dental coverage plan shall report the data elements required in Subsections 9A and B for complete plan years 2021 through 2023, by year.

E. Carriers that offer dental coverage plans that purchase a line or block of business from another carrier during a DLR reporting year are responsible for submitting the required information and reports for the assumed business, including for that part of the DLR reporting year that preceded the purchase.

F. If the Commissioner deems that data verification of a carrier's dental loss ratio for a dental coverage plan is necessary, the Commissioner shall give the carrier 30 days' notification prior to beginning the verification process with the carrier.

Section 10 Additional Data Reporting

A. On or before July 31, 2024, and on or before July 31 each year thereafter, a carrier that offers a dental coverage plan shall separately report the following data elements in the Dental Loss Ratio Reporting template provided in SERFF by the Division for the carrier's top ten dental plans for each market segment, based on enrollment in that market:

1. The number of enrollees enrolled in the carrier's dental coverage plan;

2. The plan cost-sharing and deductible amounts;

3. The annual maximum coverage limit; and

4. The number of enrollees who meet or exceed the annual coverage limit.

B. Carriers that offer dental coverage plans should also report the range of plan benefits in which enrollees met or exceeded the annual coverage limit in each market segment.

C. For the initial report due on or before July 31, 2024, a carrier that offers a dental coverage plan shall report the data elements required in subsections 10A and B for complete plan years 2021 through 2023, by year.

Section 11 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held invalid, the remainder of the regulation shall not be affected.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This regulation shall become effective on June 30, 2024.

Section 14 History

New regulation effective June 30, 2024.