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Dental Loss Ratios

Factors to Consider in Establishing a Minimum Loss Ratio for Dental Insurance in California

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Prepared by

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EXECUTIVE SUMMARY

The Affordable Care Act contains an important but little discussed consumer protection: insurers are now required to spend a minimum amount of the premiums collected on health care services and activities that improve health care quality, as opposed to administration, marketing, and profits. This consumer protection – promoted as bringing transparency, increased value and improved administrative efficiency to insurance plans – has already resulted in billions of dollars in consumer benefits in the form of rebates from insurers and premium reductions. Nevertheless, this protection applies only to health plans in group and individual insurance markets and not to dental plans.[1] This report examines the arguments for and against a minimum "Medical Loss Ratio" (MLR) as such requirements are known, explores the implementation of the Affordable Care Act's MLR in practice, and evaluates issues California policymakers and stakeholders will confront as they consider whether to adopt a minimum loss ratio for dental plans.

Minimum Loss Ratio Requirement

The requirement for a minimum loss ratio was the subject of considerable debate as the Affordable Care Act (ACA) was taking form. In favor of such a policy, consumer advocates and others argued that requiring insurers to spend a minimum amount of premiums on patient care (and report the amount they were spending) would serve as an important incentive for insurance companies to improve efficiency and increase the benefits consumers derived from their health insurance expenditures. In contrast, health plans and others argued that the requirement for a minimum loss ratio would drive insurers from the marketplace, thereby diminishing consumer choice and potentially raising, rather than lowering, insurance premiums.

Ultimately, the ACA included a minimum loss ratio provision. As a result, consumers have received billions of dollars in benefits, as estimated by both government and private economists and researchers. In addition to these consumer benefits, there has been little evidence supporting the claim that insurers would leave specific markets in sufficient numbers to destabilize those markets, thereby decreasing consumer choice and increasing premiums.

[1] California law similarly excludes dental insurance from the MLR requirements.

Factors to Consider in Establishing a Minimum Loss Ratio for Dental Insurance

The experience of the ACA MLR suggests that a minimum loss ratio policy can deliver important consumer protections and benefits as well as bring administrative efficiencies to the health insurance marketplace. And, this experience can point the way toward successful development and implementation of a minimum loss ratio policy for dental insurance in California. In developing such a policy, there are several factors that should be considered.

- *Current State of the Market.* Dental plan loss ratios vary by plan and customer type, with some plans having loss ratios that exceed 80%, though others do not achieve this level. Loss ratios are also correlated with profitability (high profits are correlated with low loss ratios) and customer type (small group plans have lower loss ratios relative to large group plans), but not necessarily with plan type (DHMO plans have average administration costs but low loss ratios).[2]
- *Important Differences between Health Plans and Dental Plans.* In applying the lessons from the ACA MLR, differences between health and dental plans should be considered. Specifically, high fixed costs as a fraction of the relatively low premiums for dental plans suggest that lower loss ratios for dental plans may be appropriate. However, claims frequency, complexity, and utilization for dental plans may be lower relative to health plans, which could result in lower administration expenses as a percent of premiums and, therefore, higher loss ratios. Therefore, while dental and health plans are similar in some respects, dental plans do not necessarily function like "low cost health plans" in terms of their administration expenses and loss ratios.
- *Changing State of the Dental Insurance Landscape*. Implementation of the ACA, a growing dental insurance marketplace, and the advent of Covered California mean that the dental insurance landscape is undergoing a period of transition. Specifically, the advent of Covered California means that many dental plans need (for the first time) to cover all medically necessary dental care expenses; but, the exchange also provides plans with access to millions of potential customers.
- *Dental Loss Ratios in California and Other States*. California can benefit from examining the experience of other states and its own public programs with respect to establishing minimum loss ratios. California's Medicaid program requires a minimum loss ratio of 70% for prepaid dental plan

[2] Based on Blue Sky Consulting Group analysis of data collected by the National Association of Dental Plans as presented in the NADP Financial Operations Report, 2009. Permission to use the NADP Financial Operations Report was granted by NADP. Copyright © 2009 National Association of Dental Plans. Additional information concerning NADP's reports and publications is available at http://nadp.peachnewmedia.com.

contracts; the Healthy Families Program required a DLR of about 80%, and Colorado requires a minimum loss ratio of about 90% for its Children's Health Insurance Program dental coverage.[3]

Conclusions

Establishing a minimum loss ratio requirement for commercial dental plans in California would represent a new policy direction for the state. However, the experience of the ACA in establishing a minimum loss ratio for health plans and a careful evaluation of the current state of affairs with respect to the dental insurance landscape can help to guide the way toward development of a sound minimum loss ratio policy for dental plans.

In fact, the experience of the ACA suggests that the minimum loss ratio policy for health plans has produced substantial consumer benefits and market efficiencies with little evidence to support the claim of destabilized insurance markets. And, while clear differences exist between dental plans and health plans, none of these differences preclude the development of a minimum dental loss ratio policy.

Establishing the proper value for a dental loss ratio will require careful analysis of the current dental insurance market, in which loss ratios vary considerably. And, development of any minimum loss ratio policy should proceed deliberately, recognizing the potential for market disruption and corresponding impacts on consumer costs and choices. Nevertheless, some insurers appear already to have loss ratios that would place them in compliance with the ACA thresholds, if these values were to be applied to dental plans. In addition, the experience of the ACA suggests that loss ratios would increase subsequent to implementation of a loss ratio policy, bringing more insurers into compliance while simultaneously increasing the value and transparency of the insurance products for consumers. To the extent that implementation of a dental loss ratio policy follows a path similar to the one blazed by the comparable health insurance policy, consumers could well experience substantial benefits in the form of reduced premiums (or rebates) or increased value from their dental insurance expenditures.

[3] Note that these loss ratios may not be directly comparable with the loss ratios reported by health insurers using the ACA methodology, which allows for quality improvement efforts to be counted in the numerator and taxes to be removed from the denominator.

INTRODUCTION

Health care is increasingly a preoccupation for people in California and throughout the country. It consumes an ever larger share of the nation's economic output, costs most Americans thousands of dollars each year, creates millions of jobs, saves lives, causes bankruptcies, and colors our political debates. In response to the large number of Americans without health insurance, the Congress passed and President Obama signed into law the Patient Protection and Affordable Care Act, (known as the "PPACA," "ACA," or just "Obamacare").

The ACA requires nearly all Americans to obtain health insurance and mandates that most employers provide coverage to employees. The act regulates insurance markets nationally, once the largely province of state regulation, and creates insurance "marketplaces" with standardized plans and benefits. The act also offers subsidies or no-cost insurance through Medicaid and Children's Health Insurance Plans to those who may not be able to afford coverage. In addition, states have the option to expand their Medicaid programs to childless adults.

Although the ACA represents perhaps the largest change to the health care landscape since the creation of Medicare and Medicaid in the 1960s, it has generally focused on health care delivered by physicians or other medical providers in hospitals and clinics, and has been largely silent on the subject of dental care and dental insurance for adults.

What is an MLR and Why Should a Minimum Value Be Established?

One of the least talked about parts of the Affordable Care Act is a provision requiring a minimum "Medical Loss Ratio" for health insurers. Traditionally, the "loss ratio" is the fraction of insurance premiums spent on delivering health care services, as opposed to paying for insurance company administration, marketing, profits and other expenses. Medical loss ratios can be used to measure financial performance, project future earnings growth, and compare the relative quality of competing plans.[4] The US Senate Committee on Commerce, Science and Transportation addressed the multiple potential uses of a medical loss ratio in a brief on implementing MLRs, stating that,

> "Regulators, policymakers, and investors look to the medical loss ratio as a basic indicator of an insurer's efficiency in delivering services and of its financial condition. While investors view a stable or declining medical loss ratio as an indicator that an insurer is controlling risk and is

[4] America's Health Insurance Plans, "State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations" (April 2010). Available online at: http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf

> more likely to be profitable, consumers and policymakers view low medical loss ratios as evidence that an insurer is spending too much money on administration and profits, and not enough on medical care." [5]

The purpose behind requiring a minimum medical loss ratio, or MLR, is to encourage health plans to become more efficient by limiting the amount that can be spent on administration and profits while maximizing the amount that is spent on delivering health care services. Fundamentally, it is a consumer protection measure designed to ensure that consumers are receiving a minimum level of benefits from their expenditures on health plans. Moreover, the MLR, provides a transparent measure of the value of services provided by a plan and allows consumers to compare such values across different plans.

The Purpose of this Report

While the ACA established a minimum loss ratio for health plans, it did not require the same for dental plans. And, while there are important differences between health insurance and dental insurance (differences addressed subsequently in this report), fundamentally a minimum loss ratio for dental plans (a "Dental Loss Ratio" or "DLR") could function much like the MLR for health insurance. This report examines the arguments for and against a minimum "Medical Loss Ratio" and provides a high-level overview of the development, implementation and impact of the ACA MLR and the lessons therein that can inform the discussions about and the development of a DLR policy for California. The report also examines some of the characteristics of dental insurance that should be considered as California addresses the question of whether to establish a "DLR" requirement for dental plans.

Experience with MLRs in the States Before the ACA

The debate concerning establishing a minimum loss ratio as part of the ACA has its roots in the states, where insurance regulation has traditionally been done. State-based MLR regulation varied widely due to the heterogeneous nature of state insurance markets. In fact, research suggests that states with

[5] US Senate, Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations, Majority Staff, "Implementing Health insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers," April 15, 2010. http://www.commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667

more competitive insurance markets generally have higher MLRs.[6] Prior to the establishment of the MLR in the ACA, most states had some form of MLR regulation[7]:

- Thirty-four states established MLR guidelines, requiring the filing or reporting of loss ratio information with state regulators, or imposed limitations on administrative expenses for comprehensive, major medical insurance.
- Ten states had adopted the 1980 NAIC Guidelines to require MLRs in the individual market. These ten states' MLRs ranged from 55% to 80%.
- In group markets, two states implemented the NAIC Guidelines as requirements for their entire group markets. Eighteen other states had some required MLR for either their small or large group markets, and in some cases, for both.

In examining this diverse state landscape, the GAO found that 64% of insurers in 2010 would have met the ACA MLR requirements.[8] (The GAO analysis took into account the ACA's expanded MLR formula and "credibility" adjustments for small insurers, which raised MLRs an average of 6.3% percentage points.)[9] The GAO research on the individual states found that a higher proportion of insurers in large and small group markets, when compared to individual market insurers, met or exceeded the ACA thresholds. Insurers in the individual market had, on average, higher expenses that were unrelated to claims such as brokers' fees and commissions.

The Federal Debate

Building on the experience of the states, supporters at the federal level suggested that establishing federal policy for a minimum MLR would serve as an important consumer information and protection tool, educating consumers about the health plan products they considered purchasing and ensuring that consumers would get at least a minimum value for their health insurance premium expenditures.[10]

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[6] Karaca-Mandic, Pinar, "Is the Medical Loss Ratio a Good Target Measure for Regulation in the Individual Market for Health Insurance?" *Health Economics*, October 2013.

[7] Americas Health Insurance Plans, "State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations" (April 2010). Available online at: http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf

[8] Government Accountability Office. "Private Health Insurance: Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards." GAO-12-90R. Available at: http://www.gao.gov/new.items/d1290r.pdf

[9] Insurers that cover less than 1,000 life years are considered "non-credible" and presumed to meet the PPACA MLR standards. Life years refers to the total number of months of coverage for all enrollees divided by 12. See 45 C.F.R. § 158.230 (as added by HHS Interim Final Rule, 75 Fed. Reg. 74864, 74927 (Dec. 1, 2010))

[10] Jost T." "Implementing Medical Loss Ratios." Health Affairs Blog. November 23, 2010. http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios/

With a minimum MLR, consumers would know more about how much of their premium expenditures were going to care, so they could make more informed purchasing decisions. Given the variability of state MLR regulation, a federal rule would assure that consumers had similar protections and standardized information regardless of location.

Simultaneously, it was argued that with a minimum MLR policy insurers would have an increased incentive to lower administration costs, marketing expenses and profits, thereby driving efficiency and bringing overall costs down. It was also argued that establishing a minimum MLR would shine a light on health plan administrative activities, encouraging these plans to develop more measurable and effective quality improvement efforts (since only certain of these activities are counted as health care expenditures as opposed to administration under the ACA).[11] Finally, it has been suggested that establishing a minimum MLR would help to ensure that only plans that meet minimum efficiency standards will prevail in marketplace.

Economic Arguments Supporting a Minimum MLR

The policy debate surrounding the adoption of an MLR also drew from the economic arguments that support a minimum MLR. Specifically, in a perfectly competitive market, a minimum MLR might not be necessary. In such a market, insurers would compete with each other to provide the best product at the lowest price. But, if the market is not competitive, then a minimum MLR can help protect consumers. One possible problem with insurance markets that would justify intervention by regulators is market concentration which gives one or a handful of companies the power to increase prices. Research suggests that this may be occurring, at least in certain health insurance markets. One study found that, "insurers with monopoly power have lower MLRs" and that, "the MLR could serve as a target measure of market power in regulating the individual market for health insurance."[12] Another recent study also found evidence indicating that health insurance markets are not perfectly competitive and linked private health insurance premiums to the market power of insurers.[13]

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[11] US Senate. Committee on Commerce, Science and Transportation. Letter to NAIC Commissioner Cline. May 7, 2010. http://www.rockefeller.senate.gov/press/5.07.10%20Letter%20to%20NAIC%20President%20Commissioner%20Jane%20Cline.pdf

[12] Karaca-Mandic, Pinar, "Is the Medical Loss Ratio a Good Target Measure for Regulation in the Individual Market for Health Insurance?" *Health Economics*, October 2013.

[13] Dafny, L., "Are health insurance markets competitive?" *American Economic Review* 100: 1399–1431, 2010.

Another important potential problem with the health insurance market relates to the information available to consumers, and their ability to interpret and use that information to make informed purchasing decisions. In general, where products are complicated and difficult to grasp, consumers may have a hard time understanding what they are buying. In these cases, companies will have an advantage in setting prices, and may earn higher profits. For health insurance companies, this may manifest itself in the form of lower expenditures on health care (i.e. a lower MLR). According to one study, consumers "looking to buy insurance face a difficult shopping problem. Savvy purchasers must consider which of the many drugs their employees might use are in the insurer's formularies, which local physicians are part of the insurer's provider network, and what co-pays, fees, and deductibles apply to which pharmaceuticals, providers and services. Comparison shopping is made even more difficult by the fact that many aspects of insurance involve commitments to provide services under hard-to-anticipate contingencies."[14]

Arguments Against a Minimum MLR

Although the minimum MLR requirements were ultimately included as part of the Affordable Care Act, some arguments were raised (primarily from health plans) against the MLR requirement.[15] These arguments generally centered around several themes.

First, that establishing such a rule would actually result in worse outcomes for consumers by limiting choice. That is, if the minimum MLR was set too high, some carriers would exit market, leaving consumers without enough choices among health plans.

The next set of concerns centered around practical difficulties in implementation. For example, health plans argued that the MLR requirements were difficult to interpret, resulting in ambiguities with respect to what constituted "administration" as opposed to health care delivery, specifically with respect to activities that health plans engage in designed to improve health outcomes. These critics argued that if expenditures on improving patient care were limited (because they count as administration), then the quality of care could suffer or efforts aimed at spurring innovation could be

[14] Cebul, Randall D., et. al., "Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance," NBER Working Paper number 14455, National Bureau of Economic Research, 2008.
[15] See, for example, the discussion of the federal MLR requirement on the America's Health Insurance Plans website: http://ahip.org/Issues/Medical-Loss-Ratio.aspx (reviewed on November 22, 2013).

curtailed. Health plans also expressed a concern that limitations on administration costs imposed by a minimum MLR requirement would limit anti-fraud activities in which health plans may engage.

Arguments were also raised indicating that loss ratios varied across types of plans, regions, and other dimensions and that a "one size fits all" approach was therefore not appropriate. For example, it was argued that small and/or rural market issuers tended to have less predictable patient care spending, resulting in changes to the MLR from year to year that could make compliance with a minimum MLR difficult. Finally, some argued that an MLR, rather than aiding consumers would actually result in confusing consumers further, as they struggled to understand the new requirements.

In the sections that follow, we explain how the ACA MLR has worked in practice and whether and to what extent the concerns raised by minimum MLR opponents have been realized.

MLRS IN PRACTICE: THE EXPERIENCE OF THE ACA

The ACA requires a minimum loss ratio for health insurance plans and limits spending on administrative costs, advertising and marketing, and other costs unrelated to delivering health care services.[16] The law requires large group plans to spend at least 85% of all premium dollars on health care services and health care quality improvement. Small group and individual plans must spend at least 80% of all premium dollars on care and quality improvement activities.[17]

Plans must report annually to the federal government with state-level data and include separate reports for each market in which they have business – large group, small group and individual. The first set of reports for 2011 was made public by the federal government in 2012. Subsequent reports covering 2012 were made available in 2013. [18]

The law specifies that if insurance plans do not meet the required minimum MLR, they must provide notices and rebates to their customers for each plan year after January 2011. Employers receiving

[16] The ACA MLR provisions are governed by regulations issued by the federal Department of Health and Human Services, which issued final regulations on November 22, 2010 and then released new final rules on December 11, 2011
[17] This rule does not , however, apply to large self-insured employer plans.
[18] Center for Consumer Information and Insurance Oversight Medical Loss Ratio Data and System Resources. HTTP://WWW.CMS.GOV/CCIIO/RESOURCES/DATA-RESOURCES/MLR.HTML

rebates must pass along the savings to employees in proportion to their contribution. Plans not providing rebates must also send notices to plan subscribers with information about the plan's MLR.

How the MLR Provisions Were Developed

The ACA charged the National Association of Insurance Commissioners (NAIC)—an organization of elected and appointed state insurance commissioners— with developing an expanded MLR formula. Traditionally, the MLR had been defined as the proportion of premiums insurers expend on health care claims. At issue in developing an expanded and uniform formula was what would count toward spending on health care versus spending on administrative activities. The final formula allows insurers to make adjustments for quality improvement activities and expenditures on taxes, licensing and regulatory fees.

The task of defining quality improvement activities proved contentious, but ultimately the NAIC specified five allowable expense categories for activities that improve patient health care quality and can be demonstrated over time. Specifically, activities count as quality improvement efforts if they: 1) improve health care outcomes; 2) prevent hospitals readmissions; 3) improve patient safety and reduce medical errors; 4) promote health and wellness; or 5) improve health care quality through health information technology.

Broker fees and commissions were included as administrative expenses despite pressure to exclude them. A GAO study found that non-claim administrative expenses, on average, represented 13, 16, and 23% of premiums in large group, small group, and individual plans, respectively.[19] Of those expenses, brokers' fees and commissions represented 3% in the large group market, 5% in the small group market, and 7% in the individual market.

With the goal of implementation flexibility, the ACA permits HHS to adjust the 80% MLR for the individual market using waivers if the state demonstrates that meeting the standard would destabilize the market and threaten consumers' coverage choices. In addition, the MLR rule excludes very small health plans (fewer than 75,000 enrollees) or allows for an adjusted MLR (referred to as a "credibility adjustment) in certain cases; new plans may delay reporting until the second plan year. Finally, the ACA made adjustments for "mini-med" plans (those with annual benefit limits up to $250,000) and expatriate plans.

[19] Government Accountability Office. *Private Health Insurance: Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards.* GAO-12-90R http://www.gao.gov/new.items/d1290r.pdf

State Waivers for MLR Adjustments

During the debate about MLRs and their potential impact, opponents feared that some insurers would exit the insurance market, thereby destabilizing markets and reducing consumers' coverage choices. The ACA allowed for flexible implementation, including the ability to grant waivers of the MLR requirement if a state demonstrated that complying with the requirement would destabilize the market. Ultimately, seventeen states applied to reduce the minimum MLR standard, with seven ultimately granted waivers.[20]

The rationale most often cited in support of waivers was a demonstrated risk of insurer exit and market shares large enough to threaten coverage for a significant number of insured. Furthermore, waiver approvals also cited the difficulty of small plans in competing with larger insurers and long-term broker commission contracts as reasons to adjust MLRs. For states granted waivers, adjustments were typically made over multiple years until the target 80 percent level was achieved. HHS stated that this approach "creates a glide path for compliance with the 80 percent standard."[21]

Waiver denials typically disagreed with a state's assertion that insurers would exit the market. HHS also identified where insurers were already near the 80% MLR standard or adapting their business models to provide consumers better value for their premium dollar. In one state's denial, HHS disagreed that consumers would lose access to insurance brokers and agents if the MLR was increased. Finally, HHS noted where plans were sufficiently profitable to provide rebate payments if they failed to meet the 80 percent MLR standard. As for insurers exiting and destabilizing the market due to higher MLR standards, there is little evidence of such exits, and the vast majority of insurers have remained in the individual market.

Impact of ACA MLRs on Consumers

Consumer Rebates and Premium Savings

In the two years during which minimum MLR requirements have been in effect, consumers have realized significant benefits. Studies by both private health care foundations and the federal government have found evidence of consumer benefits from the ACA MLR provisions. Most of the

[20] Three states applied for a reconsideration of HHS's decisions about their waivers, and all three reconsideration requests were subsequently denied.

[21] Center for Consumer Information & Insurance Oversight. State Requests for MLR Adjustment http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests.html

attention around MLRs has focused on rebates required of insurers that did not meet the standard for their respective market. But consumers also benefited from premium savings when insurers improved administrative efficiencies and reduced profits, thereby reducing premiums. Such premium reductions increased the calculated loss ratio by virtue of the increased percent of premiums spent on services and quality improvement activities.

According to a Kaiser Family Foundation study, in 2011, both rebates and premium savings together totaled $1.2 billion.[22] Rebates were paid by 14 percent of all insurers in 2011. In the second year of implementation, the federal Department of Health and Human Services reported that 77.8 million consumers saved $3.4 billion due to premium reductions. In addition, another $500 million was paid in rebates to 8.5 million insurance customers, or about $100 per family on average.[23] While the amount paid in rebates declined from 2011 to 2012, premium savings increased significantly.

The principal beneficiaries of the premium savings were those in the individual insurance market, according to an analysis by the Kaiser Family Foundation.[13] The Kaiser study found that in 2010 (prior to implementation of the ACA MLR requirement) less than half of all individual market plans met the 80 percent MLR standard. As a result, these plans needed to redirect more premium dollars to health services and fewer to administration and profit in order to reach compliance with the MLR requirement. In the small and large group markets, by contrast, most plans' MLRs in 2010 already met the ACA standard, so few plans had to make significant adjustments in businesses practices to be in compliance in 2011. An analysis of insurers' responses to MLR requirements found that individual market plans increased their MLR ratio by 5.5 percentage points from 2010 to 2011, and decreased their administrative cost ratios by 2.6 percentage points.[24] Furthermore, operating margins for these plans, on average, declined over this same period.

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[22] Cox et al. Beyond Rebates: How Much Are Consumers Saving from the ACA's Medical Loss Ratio Provision? Kaiser Family Foundation Perspective. June 6, 2013. http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/

[23] Center for Consumer Information and Insurance Oversight. 80/20 Rule Delivers More Value to Consumers in 2012. http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf

[24] McCue et al. Impact of Medical Loss Regulation on the Financial Performance of Health Insurers. *Health Affairs*, Sept. 2013 32(9):1546–51

Quality Improvement Activities

The ACA MLR requirement, by virtue of allowing quality improvement efforts to count toward health care expenses, has shed a new light on these activities on the part of insurers. A Commonwealth Fund analysis of insurers' 2011 data found that insurers' spending on activities to improve health care quality totaled $2.3 billion, or about $29 on average per insured person. Provider-sponsored and non-profit plans spent significantly more, on average, than for-profits and publicly traded plans. Of this $2.3 billion, 51 percent went to improving outcomes, 17 percent to health information technology, 13 percent to wellness activities, 10 percent to patient safety, and 9 percent to preventing hospital readmissions.

Implications for California

The experience of the ACA's minimum medical loss ratio can serve as an important guide for California policymakers and stakeholders as they evaluate whether to adopt a similar requirement for dental insurance. Specifically, the experience of the ACA suggests that consumers have received substantial benefits, with little in the way of costs and market destabilization that were predicted by opponents of the MLR rule. These positive outcomes may well stem largely from the extensive deliberations, careful policy development and flexible implementation processes that were developed as part of the health MLR rules.

FACTORS TO CONSIDER IN ESTABLISHING A MINIMUM LOSS RATIO FOR DENTAL INSURANCE

Currently, dental insurance in commercial markets in California is not subject to the minimum loss ratio requirements to which health insurance plans are subject.[25] Absent a policy change instituting a minimum loss ratio, dental plans do not need to spend a minimum amount of premium revenues on delivering dental care. As Californians consider whether to subject dental plans to the same MLR requirements as health plans, there are several factors that should be considered:

1. *Current State of the Market.* Any minimum loss ratio requirements must be evaluated in the context of the current loss ratios for California's dental insurers.

[25] Such a policy was considered in 2013 in the form of Assembly Bill 18 authored by Richard Pan, which proposed a 75% minimum loss ratio for plans providing pediatric oral care benefits in the small group market, both inside and outside of Covered California, the state's health insurance marketplace.

2. *Important Differences Between Health Plans and Dental Plans.* The experience of the ACA MLR offers a useful lesson in how to establish and implement a minimum loss ratio requirement. However, in applying these lessons, differences between health and dental plans must be considered.
3. *Changing State of the Dental Insurance Landscape*. Implementation of the ACA and the advent of Covered California mean that the dental insurance landscape is undergoing a period of transition. Understanding these changes can help inform development of a DLR policy.
4. *Dental Loss Ratios in California and Other States*. California can benefit from examining the experience of other states and its own public programs with respect to establishing minimum loss ratios.

Current State of the Market

Perhaps the most important factor to consider in establishing a minimum loss ratio for dental plans is the current state of the market. Setting a minimum loss ratio too high could destabilize the market, causing insurers to go out of business or exit the market, with a resulting decrease in consumer choice and, likely, an increase in premiums. If, however, many insurers are already performing at the level selected for the minimum loss ratio (or can reasonably be expected to achieve this level without significant changes to their business practices), then MLR requirements will result in little in the way of consumer protection (although insurers would be required to maintain the established minimum level in the future). Therefore, setting the minimum loss ratio at an appropriate level based on current market conditions and reasonable expectations about likely changes in these conditions can help to ensure both a stable market and meaningful consumer protections.

National Data

The National Association of Dental Plans (NADP) conducts regular surveys of its members, in which data are collected with respect to claims payments, and expenses for administration, taxes and profits.[26] Therefore, these data can be used to calculate loss ratios for different types of dental insurers nationally.

Evidence from the NADP data suggests that loss ratios vary based on type of product (e.g. DPPO, DHMO, or indemnity) as well as type of customer (e.g. small versus large group). Table 1 shows the

[26] NADP, Financial Operations Report, July 2009.

estimated loss ratios by plan type based on the NADP data.[27] In order to facilitate a comparison with the MLRs reported by health insurance plans as calculated under the ACA, we present the more traditional loss ratio (claims payments divided by premiums) as well as an estimate of what the loss ratio might be if calculated under the ACA rules, which allow for quality improvement efforts to be included in the numerator and taxes to be subtracted from the denominator.

As shown in Table 1, DHMO plans had the lowest estimated loss ratios, at about 65 percent, with DPPO and Indemnity plans having higher estimated loss ratios of 76 percent and 73 percent respectively. Adjusting the results to reflect the approximate methodology contained in the ACA (in which quality improvement efforts are included in the numerator and taxes are subtracted from the denominator) results in an increase in the loss ratio for all plan types, with DHMO plans showing an estimated loss ratio of 72 percent and PPO and Indemnity plans showing higher loss ratios of 80 percent and 78 percent, respectively.

TABLE 1: ESTIMATED LOSS RATIOS BY PLAN TYPE, 2008

	Plan Type		
Loss Ratio	**DHMO**	**DPPO**	**Indemnity**
Estimated Loss Ratio	65%	76%	73%
Loss Ratio Adjusted for Taxes	70%	79%	76%
Loss Ratio Adjusted for Taxes and Quality Improvement	72%	80%	78%

Source: Blue Sky Analysis of NADP data. Quality improvement estimated at 1% of total premiums[28]

The NADP data also indicate that loss ratios vary by customer type, with large group loss ratios significantly exceeding those reported by small groups (See Table 2). This relationship was consistent across plan types, with loss ratios for large groups exceeding those for small groups in each of the three plan types. Indeed, there was a significant degree of variation overall. The estimated loss ratio for large group indemnity plans was the highest, at 90 percent (using the approximated ACA methodology), while the estimated loss ratio for small group DHMO plans was the lowest, at 63 percent. Overall, DPPO

[27] Loss ratios calculated as provider payments plus estimated quality improvements efforts (where indicated) divided by estimated total premium revenues less taxes (where indicated). Total premium revenues are not reported by in the NADP data. Therefore, we have estimated total premiums as the sum of all reported expense categories plus profits.

[28] A Commonwealth Fund analysis of health insurers' 2011 data revealed that insurers spent 0.7 percent of premiums on quality improvement activities.

and Indemnity plans for medium and large groups exceeded 80 percent while all of the DHMO and small group plans came in below this level.

TABLE 2: LOSS RATIOS BY GROUP SIZE, 2008

	Plan Type		
Group Size	**DHMO**	**DPPO**	**Indemnity**
Small	63%	70%	69%
Medium	73%	80%	81%
Large	76%	85%	90%
Average	72%	80%	78%

Source: Blue Sky Consulting Group analysis of NADP data. Loss ratio calculated based on approximate ACA methodology.

Perhaps unsurprisingly, the NADP data also suggest a strong correlation between loss ratios and profitability. As Table 3, indicates, DHMO plans, which had the lowest loss ratios, also had the highest profits among each of the three plan types. Similarly, small group plans, which have lower loss ratios as compared with medium or large group plans, also have the highest profits. Large group DPPO and Indemnity plans have the highest loss ratios and lowest profits.

TABLE 3: PROFITS BY PLAN TYPE AND GROUP SIZE, 2008

	Plan Type		
Group Size	**DHMO**	**DPPO**	**Indemnity**
Small	13%	9%	9%
Medium	8%	4%	3%
Large	8%	3%	-3%
Average	11%	4%	5%

Source: Blue Sky Consulting Group analysis of NADP data. Loss ratio calculated based on approximate ACA methodology.

In contrast to the profits analysis, a review of administration expenses (shown in Table 4) suggests that total costs for administration (including billing and claims processing plus sales and marketing) are correlated with group size, but not necessarily with plan type. Small group plans had the highest administration costs, averaging about 22 percent of total estimated premiums across all plan types. Large group plans had the lowest administration costs, averaging about 14 percent across plan types. Looking across plan types, however, indicates that administration costs are relatively consistent across each of the three plans, with administration costs of 16 percent for DHMO and DPPO plans and 18 percent for indemnity plans.

TABLE 4: ADMINISTRATION COSTS BY PLAN TYPE AND GROUP SIZE, 2008

	Plan Type		
Group Size	**DHMO**	**DPPO**	**Indemnity**
Small Group	22%	21%	21%
Medium Group	18%	17%	16%
Large Group	16%	12%	15%
Average	16%	16%	18%

Source: Blue Sky Consulting Group analysis of NADP data. Values reflect total administration plus sales and marketing.

Although a complete analysis of the dental insurance market is beyond the scope of this report, these data suggest that loss ratios are not simply a function of administration expenses, but also reflect the profitability of different customers and plans.

Current Loss Ratios for Dental Plans in California

In California, many dental plans are regulated by the Department of Managed Health Care (DMHC). As part of the regulatory process, plans overseen by DMHC must submit detailed financial reports, including information on the loss ratio as reported by the plans. Although these data are self-reported by insurers and do not allow for a detailed breakdown by plan size (as with the NADP data), they do offer California specific information about the financial performance of the state's dental insurers.

According to the data that dental plans submit to DMHC, the loss ratios vary considerably, both across plans and over time. The largest plan covered by DMHC is Delta Dental. As of 2012, Delta Dental accounted for 35 percent of the total reported enrollment for commercial group plans.[29] Because the data reported to DMHC are aggregated, it is not possible to determine the loss ratio by plan type. However, among the overall loss ratios reported, Delta has among the highest reported loss ratios. In fact, for 2012, Delta was the highest of all the plans, reporting a loss ratio of 81.1 percent. This ratio –

[29] Delta accounted for a much larger 79 percent of the total reported enrollment for dental and dental/vision plans for 2012. These totals, however, include commercial group plans as well as government programs such as Medi-Cal and Healthy Families and "ASO" or administrative services only plans in which the plan is administered by a reporting entity on behalf of a self-insured group such as a large employer. In addition, Delta's 2012 reported enrollment includes more than 7 million enrollees under the category "Medi-Cal At Risk." However, Medi-Cal did not provide dental coverage to adults, except for some emergency services, during 2012. Therefore, these total enrollment figures do not appear to be useful as reported .

calculated across all of the plan types – is simply the ratio of claims payments to premiums collected, and does not reflect the ACA adjustment for quality improvements or taxes, which, if applied, would serve to increase the reported ratio. Other entities reported loss ratios ranging from 38.1 percent to 80.8 percent. (We note that some dental plans, including some indemnity insurance plans which had the highest loss ratios reported in the NADP data, are regulated by the California Department of Insurance. Financial data for these insurers was not available for purposes of the analysis presented in this report.)

Because of its aggregated nature, the data reported to DMHC is of limited value in terms of evaluating loss ratios. Nevertheless, examining just those entities that had commercial enrollees (but no government or ASO enrollees) reveals a similar range, with the highest reported loss ratio for 2012 coming in at 80.8 and the lowest at 38.1 (without making the adjustments for quality and taxes per the ACA methodology).

Important Differences Between Health Plans and Dental Plans

Health plans and dental plans differ in important respects, which may influence the appropriate level of a minimum loss ratio. Some of these factors suggest that the loss ratio for dental plans, which tend to have much lower premiums relative to health plans, should be lower, while others suggest the opposite. An analysis by the consulting firm Milliman commissioned by the National Association of Dental Plans examined the potential impact of a minimum loss ratio policy on dental plans, specifically addressing the impact of such policies given the relatively low premiums of these plans as compared to health plans.[30] The Milliman report, however, did not specifically compare dental and health plans with respect to claims frequency or complexity, but instead presented data on the current average loss ratios for a handful of national and California dental plans. Nor did the Milliman report estimate what change in these loss ratios might result if the ACA methodology were applied or if insurers faced an incentive in the form of new regulations to increase loss ratios. What is clear, however, is that careful analysis of the differences and similarities between health and dental plans should be considered in establishing any minimum loss ratio policy for dental plans.

Fixed Costs as a Percent of Premiums

Costs to administer claims and bill customers are a cornerstone of the administration expenses for both health and dental plans. Some of these costs are fixed, some vary with the number of customers, and

[30] Joanne Fontana and Tom Murawski, Memorandum to the California Association of Dental Plans.

some vary with the number and complexity of claims. Because dental plans have much lower premium revenues per customer relative to health plans, larger fixed costs and larger per customer costs can increase administration expenses as a percent of premiums collected.

For example, insurers may face a fixed cost to set up a billing and payment processing system. While the cost of such a system may vary somewhat with the number of customers, a large fraction of the cost is fixed regardless of whether a plan has a few hundred thousand customers or a few million. Similarly, some costs, such as monthly invoicing, are incurred on a per customer basis. These costs increase with the number of customers, but the per-customer cost is likely to be relatively similar regardless of whether the customer is purchasing dental insurance or health insurance. Again, because dental insurance premiums are much lower than health insurance premiums, these per-customer costs are likely to constitute a relatively larger fraction of total premium revenue.

Table 5 shows a hypothetical example of monthly billing costs for a low premium plan, such as a dental plan, and a high premium plan, such as a health plan.[31] As Table 5 shows, for the low premium example, monthly billing costs constitute 3.3 percent of monthly premium revenues. However, for the high premium example, the same $1 per member per month billing cost is just 0.3 percent of monthly premium revenues.

TABLE 5: EXAMPLE OF BILLING COSTS

Description	Cost	Monthly Premium	Cost as a % of premiums
Monthly billing - low premium	$1.00	$ 30	3.3%
Monthly billing - high premium	$1.00	$ 300	0.3%

Recognizing the impact of such fixed and per-customer costs, the National Association of Insurance Commissioners suggests that lower loss ratios may be appropriate under certain circumstances, such as for limited benefit health insurance products or other low premium health plans.[32]

Although the difference in fixed costs measured as a percent of premiums can be quite significant, as the example in Table 5 suggests, these costs comprise a relatively small share of overall premium revenue when compared with costs for claims administration. According to data from the NADP, costs "Billing/Case Setup" comprised about 0.8 percent of total reported expenses plus profits (whereas claims processing was 1.9 percent and "Other Administration" 6.2 percent).

[31] A hypothetical example was utilized because actual billing cost data was not available for analysis.
[32] NAIC, "Guidelines for Filing of Rates for Individual Health Insurance Forms," Model Regulation, July 2000

Range and Complexity of Health Versus Dental Claims

While some costs are fixed or fixed on a per-customer basis, others can vary significantly based on the type of customer or type of product. For example, dental plans may have significantly fewer claims per member relative to health insurance plans and the complexity of these claims may also be significantly lower and therefore less costly to administer. Furthermore, the customer services associated with plan administration (e.g. – help finding a clinician, explaining premiums and benefits) and claims processing (e.g. – explaining denials or informing about the adjudication process and timing) likely differ between health and dental plans.

Table 6 presents a hypothetical example of a low premium plan, such as a dental plan, and a high premium plan, such as a health plan. As the example in Table 6 suggests, if the low premium plan has fewer claims and each of these claims is less costly to administer relative to a high premium plan, the costs as a fraction of total premium revenues is correspondingly lower.

TABLE 6: EXAMPLE OF CLAIMS COSTS

Description	Claims/ year	Admin Cost/ Claim	Claims Admin Cost/year	Annual Premium	Cost as a % of Premiums
Monthly billing - low premium	2	$ 3	$ 6	$ 360	1.7%
Monthly billing - high premium	7	$ 10	$ 70	$ 3,600	1.9%

In addition to differences in terms of the number of claims processed, dental and health plans may differ in terms of the complexity of these claims. For example, a review of the possible procedure codes utilized for dental and health claims billing indicates that there are approximately 26 times more codes for health than there are for dental, suggesting that health claims may be more complicated and therefore more costly to administer.[33]

Extent of Annual Variation in Claims Costs

Another important potential difference between health and dental plans relates to the extent of variability in annual claims costs. To the extent that claims costs vary significantly from year to year,

[33] There are 15,971 medical codes and 610 dental codes used by the Medi-Cal program for claims. Medi-Cal fee-for-service medical CPT codes available at http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp and dental procedure billing codes from the Medi-Cal Dental Program Provider Handbook available at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf#page=161

insurers need to maintain adequate reserves in order to pay unexpectedly high claims. This variation can lead to swings in the loss ratio, and can increase costs for insurers with correspondingly lower loss ratios.

While an analysis of the variability in claims costs is beyond the scope of this report, it is likely that dental plans in general experience less variability in annual claims costs as a result of the more limited set of covered procedures and cap on covered expenses which is characteristics of most dental plans.

Changing State of the Dental Insurance Landscape

Any effort to develop a minimum loss ratio for dental plans in California must take into account the changing nature and size of the dental insurance landscape. Specifically, the implementation of the ACA has resulted in a new and growing marketplace in which dental insurance can be purchased, as well as new requirements for insurers participating in this market.

One example of such a change is the requirement to cover all medically necessary procedures. Insurers participating in Covered California will now need to provide insurance which covers all medically necessary dental procedures without regard to a maximum annual cap on expenditures. Previously, most dental insurance functioned more like pre-paid dental care rather than true indemnity insurance in that virtually all plans had a relatively low annual cap on covered expenditures (e.g. $2000 per year). Now, many plans will for the first time need to cover expenditures beyond any such cap. Without a claims experience to rely on in setting premiums, such a change may cause temporary disruptions in the dental insurance market as insurers determine how to price their plans in response to this new requirement.

Another important change relates to participation in the exchange itself. Whereas previously many insurers relied on a broker network or other means of marketing their products, many customers will now have the ability to look for and enroll in dental plans via the state's insurance exchange, Covered California. While the actual impact on costs cannot yet be determined, the ability for customers to choose a plan through Covered California may result in lower sales and marketing costs for insurers, who will now be able to present their products to millions of Californians at a relatively low cost.
In addition, pediatric dental services are part of the ten essential health benefits required by the ACA. Dental plans participating in Covered California may offer stand-alone options for pediatric services or dental services may be "bundled" into health plans. Covered California is currently working with stakeholders and plans to determine how to offer dental services for children. How dental plans are ultimately structured – as stand-alone plans or "bundled" – would have implications for administrative

and other costs used to determine loss ratios. These and other changes brought about by the ACA and the changing dental insurance landscape can have important implications for a DLR policy.

Dental Loss Ratios in California and Other States

Requirements for minimum loss ratios for dental plans are not unprecedented, either in California or other states. The California Healthy Families Program, for example, required contracting dental plans to spend around 80 percent of premiums on services for enrollees.[34] Plans failing to meet the DLR would be required to file corrective action plans and credit the state for the amount under the requirement minimum. The Medi-Cal program requires a minimum loss ratio for dental managed care plans of 70 percent. The Department of Health Care Services can recover administrative costs by plans in excess of 30 percent.

In Colorado, the Children's Health Insurance Program contract locks the minimum loss ratio for dental services at either 91 percent or 92 percent depending on average monthly membership in the program. Nevada also has a loss ratio for dental plans though it is a "safe harbor limit" of 75 percent and allows plans leeway to adjust and defend lower amounts. Florida has a mandated 85 percent minimum loss ratio for prepaid dental plans in the Medicaid program.

IMPLICATIONS FOR ESTABLISHING A DLR IN CALIFORNIA

While establishing a minimum loss ratio for dental plans in California would represent a new policy direction for the state, the experience of the ACA in establishing a minimum loss ratio for health plans and a careful evaluation of the current state of affairs with respect to the dental insurance landscape can help to guide the way toward development of a sound minimum loss ratio policy for dental plans. Should California seek to establish such a policy, several important principles can be gleaned from the ACA experience and an examination of the dental insurance landscape in California:

1. *Seek input from insurance regulators.* The health MLR in the ACA was developed in close cooperation with the National Association of Insurance Commissioners. These insurance regulators had an important opportunity to suggest detailed policy recommendations that likely contributed to the success of the MLR implementation. In California, a similar process could involve input from the state's two insurance regulators, the Department of Managed Health Care and the California Department of Insurance. These entities have experience with insurance regulation, familiarity with

[34] Managed Risk Medical Insurance Board. Presentation on MLRs. Contracts with plans are confidential so specific DLR requirements not available. http://www.mrmib.ca.gov/MRMIB/HFP/Terresa_Krum_Minimum_Loss_Ratio.pdf

the current market conditions in California, and experience in implementing the ACA MLR requirement. These regulators would also understand the impact of any new regulation on administrative costs to the state.

2. *Carefully define terms*. As the ACA MLR rules were being developed, the NAIC carefully evaluated terms and policy details to make sure that the resulting policy could be workable in practice. For example, much attention was given to the issue of what constitutes quality of care improvements, so that these expenditures are legitimately aimed at improving care rather than simply allowing insurers to reclassify existing administration expenditures as quality of care expenses. Because of the significant differences between health and dental plans, the quality of care principles in the ACA MLR should be re-evaluated in the context of dental care.

3. *Recognize the need for flexibility during roll out*. The ACA MLR included several policy features that allowed insurers in particular markets or regions to adjust gradually to the MLR requirements. For example, insurance regulators in individual states had the opportunity to request waivers of the MLR requirements if it was determined that complying with these requirements would destabilize individual markets. These waivers often included a phase in, so that insurers could gradually adjust to the new requirements. Certain plans, such as very small or newly developed plans, were also offered adjustment periods. In California, the changing insurance landscape particularly with respect to the requirement for some plans to cover all medically necessary care means that such flexibility will be important.

4. *Different standards may be required for small and large group plans or different product types*. The differences in administration costs and the resulting impact on loss ratios suggest that, as with the ACA, different standards for individual and small group plans on the one hand and large group plans on the other may be warranted. A careful examination of administration costs as well as the extent of profitability and other factors which may vary by group size or product type should be conducted.

5. *Set an achievable goal that maintains consumer protections*. The minimum loss ratios included with the ACA were set in such a way that they balanced consumer protection with the realities of the insurance marketplace. That is, these minimum loss ratios were set in such a way that they provided meaningful protections for consumers, but were nevertheless achievable for most insurers. National data for dental plans suggests that there is considerable variation across plan types and group sizes, but also that many plans already have high loss ratios. Additional data with respect to the actual loss ratios for California dental plans is needed before a specific value can be established. However, the balance struck by the ACA and a recognition of the fact that MLRs did increase subsequent to implementation can serve as a guide for California policy makers.

6. *Require uniform data and reports from insurers*. In order to monitor and evaluate a minimum loss ratio policy, improved data collection will be needed in California. Currently, there is not a standard definition of what to include in a DLR calculation. Furthermore, plans often report aggregated data for multiple lines of business (e.g. dental and vision), making understanding of dental plan performance difficult.

7. *Carefully Monitor Market During Implementation*. Because of the potential for a minimum loss ratio to destabilize insurance markets, careful monitoring during the roll out of the policy should be pursued.

What is the Right Number?

The principles discussed above can help guide the way toward development of a workable minimum loss ratio policy. Nevertheless, establishing the precise value for a minimum loss ratio for dental plans in California will comprise a complicated and no doubt controversial process. A previous examination of dental loss ratios suggested that the minimum loss ratio for dental plans should be set at a level lower than that established for health plans, and even indicated that loss ratios as low as 42 percent could be considered reasonable.[35] The research and analysis presented here indicates that loss ratios for dental plans vary based on the plan and customer type, with some types of plans having loss ratios as high as 90 percent (well in excess of the ACA threshold) while others were as low as 63 percent.[36] And, this analysis suggested that some of the plans with the highest loss ratios also had the highest profits. Furthermore, these estimated loss ratios do not account for any behavioral response on the part of dental plans as a reaction to a new minimum loss ratio requirement, though the experience of the ACA suggests that at least some insurers would increase loss ratios.

To the extent that California pursues a "DLR" policy, establishing the value for such a loss ratio should not be undertaken reflexively, but should instead be based on a careful analysis of the current state of the market, expectations for changes to that market (including the likelihood that loss ratios would increase in response to regulation, as occurred with the ACA), and a careful analysis of the fixed and variable cost factors and profitability profiles that may influence the ability of insurers to adjust to a minimum loss ratio policy.

[35] Joanne Fontana and Tom Murawski, Memorandum to the California Association of Dental Plans.
[36] Loss ratios calculated based on national NADP data and application of the approximate ACA methodology.

CONCLUSION

Establishing a minimum loss ratio requirement for commercial dental plans in California would represent a new policy direction for the state. However, the experience of the ACA in establishing a minimum loss ratio for health plans and a careful evaluation of the current state of affairs with respect to the dental insurance landscape can help to guide the way toward development of a sound minimum loss ratio policy for dental plans.

In fact, the experience of the ACA suggests that the minimum loss ratio policy for health plans has produced substantial consumer benefits, as well as marketplace efficiencies, with little evidence to support the claim of destabilized insurance markets. And, while clear differences exist between dental plan and health plans, none of these differences preclude the development of a minimum dental loss ratio policy.

Establishing the proper value for dental a loss ratio will require careful analysis of the current dental insurance market, in which loss ratios vary considerably. And, development of any minimum loss ratio policy should proceed deliberately, recognizing the potential for market disruption and corresponding impacts on consumer costs and choices. Nevertheless, some insurers appear already to have loss ratios that would place them in compliance with the ACA thresholds, if these values were to be applied to dental plans. In addition, the experience of the ACA suggests that loss ratios would increase subsequent to implementation of a loss ratio policy, bringing more insurers into compliance while simultaneously increasing the transparency and value of the insurance products for consumers. To the extent that implementation of a dental loss ratio policy follows a path similar to the one blazed by the comparable health insurance policy, consumers could well experience substantial benefits in the form of reduced premiums (or rebates) or increased value from their dental insurance expenditures.