REPORT OF MEDICAL LOSS RATIO

EXAMINATION

OF THE

KAISER PERMANENTE INSURANCE COMPANY

AS OF

DECEMBER 31, 2023

Insurance Commissioner

Filed on July 2, 2026

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Los Angeles, California
May 27, 2026

Honorable Ricardo Lara
Insurance Commissioner
California Department of Insurance
Sacramento, California

Dear Commissioner:

Pursuant to your instructions, a Medical Loss Ratio examination was made of the

KAISER PERMANENTE INSURANCE COMPANY

(hereinafter also referred to as the Company). The Company's statutory home office is located at One Kaiser Plaza, 22nd Floor, Oakland, California 94612.

SCOPE OF EXAMINATION

We have performed a Medical Loss Ratio (MLR) examination of the Company to determine compliance with California Insurance Code (CIC) Section 10112.25 related to minimum MLR requirements. CIC Section 10112.25 grants the Insurance Commissioner authority to adopt regulations to implement the MLR, as described under Section 2718 of the federal Public Health Service Act. Section 2718 of the federal Public Health Service Act authorizes the U.S. Code of Federal Regulation (CFR) Title 45 – Public Welfare Part 158 to be implemented. This examination covered the three-year aggregate reporting period from January 1, 2021 through December 31, 2023.

We performed procedures established by the U.S. Department of Health & Human Services (HHS) to examine the MLR Annual Reporting Form, as completed by the Company and submitted to HHS for the 2023 MLR reporting year, to ensure the validity of the underlying data, accuracy of the calculation, and accuracy and timeliness of the rebate payments made and reported in compliance with Title 45 CFR Part 158. Title 45 CFR §158.403(a)(2) permitted HHS to accept the State's audit provided it, amongst other things, reports on the validity of the data regarding expenses and premiums that the issuer reported to the Secretary of HHS, including the appropriateness of the allocations of

expenses used in such reporting and whether the activities associated with the issuer's reported expenditures for quality improving activities meet the definition of such activities. Title 45 CFR §158.403(a)(3) further permitted HHS to accept the State's audit provided it also, amongst other things, reports on the accuracy of rebate calculations, and the timeliness and accuracy of rebate payments.

OWNERSHIP

The Company is a member of an insurance holding company system of which Kaiser Foundation Health Plan, Inc. (KFHP) is the ultimate controlling entity. The Company is a California insurance company whose voting stock is owned 50% by KFHP, a California non-profit public benefit corporation. The remaining 50% of the Company's voting stock is owned by the following Permanente Medical Groups:

- Southern California Permanente Medical Group (15%)
- The Permanente Medical Group, Inc. (15%)
- Colorado Permanente Medical Group, P.C. (4%)
- Hawaii Permanente Medical Group, Inc. (4%)
- Mid-Atlantic Medical Group, P.C. (4%)
- Northwest Permanente, P.C. (4%)
- The Southeast Permanente Medical Group, Inc. (4%)

The Company has no subsidiaries. KFHP also owns 100% of the issued and outstanding preferred stock of the Company. The Company's shares are not publicly traded and there are no stockholders.

TERRITORY AND PLAN OF OPERATION

As of December 31, 2023, the Company jointly markets its indemnity health and dental products alongside prepaid health care plans. The Company uses the same sales force employed by Kaiser Foundation Health Plan, Inc. (KFHP). The Company offers point-of service (POS); preferred provider organization option (PPO); out-of-area health (OOA); exclusive provider organization product (EPO); and dental coverage. The POS product is

a single benefit product with three tiers: medical services through prepaid group coverage to be provided by KFHP, medical services through a national contracted provider network, or medical services through any licensed non-participating provider. The PPO option offers the members within an employer group referral-free access to a private healthcare system network of participating providers or any other licensed provider nationwide. The Company's OOA product consists of indemnity health care coverage to subscribers who do not live in KFHP's service area but live in the United States. The Company's EPO product is an individually underwritten group plan which provides exclusive benefits and services utilizing KFHP's provider network. KFHP providers bill the Company on a fee-for-services basis for medical and surgical services provided to the EPO organization. The Company is an administrator for Kaiser Permanente's Self-Funded Program. Each self-funded plan, through its plan sponsor, will contract with the Company to provide administrative services only (ASO) for the self-funding plan. The Company contracts with Harrington Health, a Third-Party Administrator, to provide certain administrative services for Kaiser Permanente's Self-Funded Program such as claims processing, eligibility information and benefits. The Company offers Specific Excess of Loss and Aggregate Excess of Loss Insurance for employers with self-funded employee health benefit plans. Under Specific Excess of Loss Insurance, the employer is insured against large individual claims in excess of the specified deductible. Under Aggregate Excess of Loss Insurance, the employer is insured against excessive health care costs for its entire covered employee pool. The excess of loss insurance is only available to plan sponsors who are a part of Kaiser Permanente's Self-Funded Program.

The Company is licensed to write business in the following 12 states and the District of Columbia: California, Colorado, Georgia, Hawaii, Kansas, Maryland, Missouri, Ohio, Oregon, South Carolina, Virginia, and Washington. For the year ending December 31, 2023, the Company wrote in California, Colorado, Georgia, Hawaii, Maryland, Missouri, Virginia, and the District of Columbia, with the majority of direct premium generated in California (46%) and in Georgia (30%).

MEDICAL LOSS RATIO REPORTING FORM

Title 45 of the U.S. Code of Federal Regulations (CFR) §158.110(b) requires that a report for each Medical Loss Ratio (MLR) reporting year be submitted to the Secretary of the U.S. Department of Health and Human Services by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary. Based on the review of the filing, the Company filed an acceptable form by July 31, 2024, for the 2023 reporting year, and complied with Title 45 CFR §158.110(b).

Title 45 CFR §158.210(a) requires that an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85% for the large group market segment. Title 45 CFR §158.210(b) and (c) require that an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80% for the small group, individual, and student health market segments.

For the year ended December 31, 2023, the Company wrote $169.64 million in direct Accident and Health (A&H) business, concentrated in California (46%) and Georgia (30%). The examination focused solely on the review of the Company's California and Georgia MLR Reporting Forms.

The three-year adjusted aggregated numerator and denominator, along with the resulting credibility-adjusted MLRs for 2023, are shown in the following tables. The tables indicate that there were differences between the amounts in the "As Filed" and the amounts "As Recalculated" rows, which reflect the net impact of the adjustments made due to the identified findings as a result of this examination. The recalculated MLRs did not result in the Company owing rebates.

California – Small Group

	Numerator	Denominator	MLR
As Filed	$29,254,445	$31,611,060	97.5%
As Recalculated	$29,254,445	$31,611,060	97.5%
Difference	$0	$0	0%

California – Large Group

	Numerator	Denominator	MLR
As Filed	$88,771,951	$92,835,909	98.1%
As Recalculated	$84,612,846	$92,835,909	93.6%
Difference	$4,159,105	$0	4.5%

California – Student Health Plans

	Numerator	Denominator	MLR
As Filed	$1,620,646	$1,798,879	90.1%
As Recalculated	$1,383,652	$1,798,879	76.9%*
Difference	$236,994	$0	13.2%

Georgia – Small Group

	Numerator	Denominator	MLR
As Filed	$12,713,896	$15,037,901	91.6%
As Recalculated	$12,713,896	$15,037,901	91.6%
Difference	$0	$0	0%

Georgia – Large Group

	Numerator	Denominator	MLR
As Filed	$114,374,889	$95,713,726	121.9%
As Recalculated	$114,374,889	$95,713,726	121.9%
Difference	$0	$0	0%

*Under Title 45 CFR §158.230(c)(3), a health insurance issuer's MLR is considered "non-credible" if it is based on experience of fewer than 1,000 life-years. The Company's California student health plans are considered non-credible because they have fewer than 1,000 life-years. Title 45 CFR §158.230(d) provides that if an issuer's MLR is non-credible, it is presumed to meet or exceed the standard MLR. Therefore, the recalculated MLR for California student health plans did not result in the Company owing rebates.

COMMENTS ON MEDICAL LOSS RATIO

Medical Loss Ratio Numerator

According to Title 45 of the U.S. Code of Federal Regulations (CFR) §158.221(b), the

numerator of the Medical Loss Ratio (MLR) calculation is comprised of incurred claims, as defined in Title 45 CFR §158.140, plus expenditures for activities that improve health care quality, as defined in Title 45 CFR §§158.150 and 158.151. The data used to calculate the following MLR numerators for all applicable market segments in California and Geogia were reviewed:

Incurred Claims

According to Title 45 CFR §158.140(b)(2)(iii), the amount of incentive and bonus payments made to providers must be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers. The Company failed to demonstrate that incentive payments reported in its California 2022 and 2023 MLR Annual Reporting Forms, Part 2, Line 2.11a and Line 2.11b were tied to well-documented clinical or quality-improvement standards.

As a result, the Company overstated the three-year aggregate incurred claims reported on its California 2023 MLR Annual Reporting Form by $4,159,105 and $236,994 in the large group market and student health plans market segments, respectively. The breakdown of the reporting error by year and the total three-year aggregate is presented in the table below.

Medical Incentive Difference	2021	2022	2023	Three-year Aggregate
Large Group Market	$ 0	$ 1,539,767	$ 2,619,338	$4,159,105
Student Health Market	$ 0	$ 152,989	$ 84,004	$ 236,994

It is recommended that the Company implement procedures to ensure compliance with Title 45 CFR §158.140(b)(2)(iii), which requires that amount of incentive and bonus payments to providers be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.

The Company complied with the requirement for all market segments in Georgia.

Quality Improvement Activities

The Company did not report on any health care quality improvement activities expenses in the 2023 MLR Annual Reporting Form in California and Georgia.

Medical Loss Ratio Denominator

According to Title 45 CFR §158.221(c), the denominator of the MLR calculation is comprised of premium revenue, as defined in Title 45 CFR §158.130, minus federal and state taxes, and licensing and regulatory fees, as described in Title 45 CFR §158.161(a), and Title 45 CFR §158.162(a)(1) and (b)(1). The data used to calculate the following MLR denominators for all applicable market segments in California and Geogia were reviewed:

Earned Premium

As defined by Title 45 CFR §158.130, earned premium includes all amounts paid by a policyholder or subscriber as a condition of receiving coverage from the insurer. A sample of premium transactions was reviewed to verify the accuracy and appropriateness of the earned premium, including the verification of the data used by the Company to calculate earned premium and the validation of a sample of policy premiums reported by the Company. Based on the review, it was determined that the Company complied with the requirement.

Federal and State Taxes, Licensing and Regulatory Fees

Title 45 CFR §§158.161, 158.162, and 158.170 provide guidance on the reporting of federal and state taxes, licensing, and regulatory fees, including the reasonableness of the allocation methodology, as part of the denominator. A review of the Company's federal and state taxes, licensing, and regulatory fees, along with the allocation methodology on the 2023 MLR Annual Reporting Form determined that the Company complied with the requirement.

Credibility Adjustment

According to Title 45 CFR §158.232, the credibility adjustment is the product of the base credibility factor multiplied by the deductible factor. Based on the review, the Company appropriately calculated the credibility adjustments for all applicable market segments in California and Georgia.

Credibility Adjusted Medical Loss Ratio

According to Title 45 CFR §158.221(a), the calculation of MLR is the ratio of the numerator to the denominator, subject to the applicable credibility adjustment, if any. Based on the review, the Company appropriately calculated the credibility adjusted MLRs for all applicable market segments in California and Georgia.

REBATE NOTICE

According to Title 45 of the U.S. Code of Federal Regulations (CFR) §158.250(a) and (b), a notice of rebate is required when the Medical Loss Ratios (MLR) do not exceed the minimum standard. The Company's 2023 MLR exceeded the minimum standard in all applicable market segments in California and Georgia, and no rebates were issued.

REBATE PAYMENTS ON SOLVENCY

According to Title 45 of the U.S. Code of Federal Regulations §158.270(a), rebate payments having any adverse impact to the Company's Risk Based Capital (RBC) level requires notification by the California Department of Insurance to the Secretary of the U.S. Department of Health & Human Services (HHS). Based on the review, the Company's MLRs exceeded the minimum standard for all market segments, and no rebates were issued. Therefore, there was no adverse impact on the RBC level that would warrant notification to the Secretary of HHS.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

Current Report of Examination

Incurred Claims (Page 6): It is recommended that the Company implement procedures to ensure compliance with Title 45 of the U.S. Code of Federal Regulations §158.140(b)(2)(iii), which requires that the amount of incentive and bonus payments to providers be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.

Previous Report of Examination

None.

ACKNOWLEDGMENT

The courtesy and cooperation extended by the Company's employees during the course of this examination are hereby acknowledged.

Respectfully submitted,

Voong, Amy

Digitally signed by Voong, Amy
Date: 2026.07.02 14:17:24 -07'00'

Amy Voong, CFE
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Associate Insurance Examiner
Department of Insurance
State of California

Cuauhtémoc Beltrán

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