April 27, 2005

RE: Implementation of AB 1962 (Skinner – Chap. 567, Stats. of 2014) – Medical Loss Ratio

Dear Interested Stakeholder:

AB 1962 (Skinner – Chap. 567, Stats. of 2014) requires health plans and health insurers that offer, sell, issue, or renew a specialized health plan contract or health insurance policy covering dental services to file a Medical Loss Ratio report that contains the same information required in the 2013 federal Medical Loss Ratio Annual Reporting form (Federal MLR reporting form). Pursuant to AB 1962, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) (collectively known as "the Departments") are authorized to issue guidance to health plans and health insurers subject to the provisions of the bill regarding compliance. Such guidance is not subject to the provisions of the Administrative Procedures Act.

The Departments issued draft guidance, the reporting form and instructions on March 2, 2015. After receiving public comments, the Departments finalized the guidance, reporting form and instructions as attachments below. Pursuant to AB 1962, the Departments' guidance, reporting form and instructions are based on the Federal MLR reporting form and regulations to the extent applicable to dental plans and insurers.

The attachments are as follows:

- Attachment 1 – Reporting Form
- Attachment 2 – Instructions for Reporting
- Attachment 3 – Guidance

Background:

AB1962 requires California dental plans (CA Dental Plans) to submit a Medical Loss Ratio (MLR) annual report using the 2013 Federal MLR report form and instructions. The MLR annual report is due no later than September 30, 2015 and each year thereafter. AB1962 requires the Departments to collect three (3) years of data, as applicable. In addition, AB1962 authorizes DMHC and CDI to work together to issue guidance to the dental plans and insurers regarding compliance with the AB 1962 provisions. The dental MLR data is intended to be used by Legislature in adopting a MLR standard, which would take effect no later than January 1, 2018.

Federal MLR regulations, reporting forms and reporting instructions were designed by the Centers for Medicare and Medicaid Services (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO) for full service plans who may offer medical insurance products in multiple states. The Departments are proposing revisions to the federal regulations, reporting form and instructions to capture the products types and market categories pertaining to dental plans and insurers. The Departments removed the reporting segments that are not applicable to CA Dental Plans and added the reporting segments pertaining to CA Dental Plans that were not addressed by the Federal MLR reporting form.

The proposed guidance, reporting form and reporting instructions pertain to the 2014 reporting year. Changes may be considered in the subsequent reporting years to adapt any changes in the Federal MLR rules as well as any changes in the dental market.

The following paragraphs describe the major changes proposed to be made to the Federal MLR reporting form for application by CA Dental Plans:

A. Scope and Applicability

AB 1962 applies to health plans and health insurers who offer stand-alone dental coverage including the stand-alone pediatric dental product inside Covered California. The pediatric dental coverage bundled with the medical coverage is exempt from AB1962 as this type of product is subject to the Federal MLR rules, 45 CFR Part 158. In addition, AB1962 does not apply to a health care service plan contract or a health insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with federal Patient Protection and Affordable Care Act (Public Law 111-148).

AB1962 is a reporting requirement and the dental plans and dental insurers are not subject to rebate calculation and rebate payment. Thus, the Departments did not include any requirements or information related to the rebate in the MLR form.

B. Market and Product Type

AB 1962 requires the dental MLR information to be presented by market and product type. The Federal MLR rules require the MLR information by market only. The dental MLR form provides first level of reporting by Dental HMO (DHMO) and Dental PPO (DPPO) products. The DHMO product is to include the Knox-Keene Point of Service product grandfathered plans for former Knox-Mills licensed dental plans. The DPPO is to include indemnity dental insurance products. The next level of reporting under each type of product is to distinguish by individual, small group and large group markets. DHMO and DPPO products are separated because these two types of products may yield different dental loss ratios due to the differences in their payment mechanisms. There are stand-alone pediatric dental products offered through Covered California to individual and small group markets. The pediatric dental products have relatively small enrollment when compared with the whole dental market. According to Covered California's website, there are total of 26,071 enrollees in all individual market stand-alone dental plans as of April 30, 2014. The pediatric dental enrollees purchasing HMO products in individual market are approximately 5% of the total enrollees in the individual market under the DMHC's jurisdiction. Moreover, the percentage is not anticipated to grow as Covered California has designed its 2015 benefits to encourage embedded pediatric dental benefits in the full-service plans. All CDI-regulated products in the individual health insurance market have embedded pediatric benefits. Because the stand-alone pediatric product is not anticipated to have a significant impact on the dental MLR, the Departments will not collect pediatric data separately.

C. Mini-Med Plans

The Federal MLR rules define mini-med plans as products with a total annual limit of $250,000 for the individual, small group and large group markets. California's dental product annual limits are much lower. The Departments have concluded that the reporting of mini-med plan is not applicable to CA Dental Plans and insurers. Thus, the Departments did not include this product type in the MLR reporting form.

D. Expatriate Plans

Under the Federal MLR rules, "expatriate plans" refers to group policies that cover employees working outside their country of citizenship; employees working outside of their country of citizenship and outside the employer's country of domicile; and non-U.S. citizens working in their home country. The Departments do not license dental plans and insurers with this type of product. Thus, the Departments did not include this products type in the MLR reporting form.

E. Student Market/Student Health Plans

Under the Federal MLR rules, "student market" means the market for student health insurance coverage. The Departments do not have dental plans and insurers that offer the student dental products separately. Thus, the Departments did not include this product type in the dental MLR reporting form and did not include any reference to student administrative health fees and student health insurance coverage in the guidance. Information regarding dental coverage for students is to be included in the DHMO and/or DPPO product by the dental plans and insurers, if applicable.

F. Aggregate 2% Rule

Under the Federal MLR rules, if the issuer's total earned premium for health insurance coverage in the individual, small group, and large group markets, including any active and credible mini-med policies for a particular State, is less than 2% of its total health earned premium for that State, the issuer may choose to combine with Government Program Plans and Other Health Business experience. The Departments' conclude that this rule is not applicable to dental plans and insurers. Thus, the Departments did not include the aggregate 2% rule in the MLR reporting form.

G. Dual Contract Group Health Coverage

The Federal MLR rules define a dual contract as,

> ". . . where a group health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, experience may be treated as if it were all related to the contract provided by the in-network issuer. However, if the issuer chooses this method of aggregation, it must apply it for a minimum of 3 MLR reporting years."

The Departments' review indicates that full-service plans and insurers reported an insignificant amount from dual contracts on the Federal MLR reporting form for 2013. The Departments also found that dental products have very few dual contract options. Thus, the Departments did not include the dual contract in the dental MLR reporting form. If any dental plan or insurer provides dual contract dental coverage, the in-network and out-of- network experience will be reported separately by the reporting entity that offers the benefit in the MLR reporting form.

H. Deferred Business/Experience

Under the Federal MLR rules,

> "If, for any aggregation as defined in 45 CFR §158.120, 50% or more of the total earned premium for an MLR reporting year is attributable to newly issued policies with less than 12 months of experience in that MLR reporting year, then the experience of these policies may be deferred, at the option of the issuer. If an issuer defers the reporting of newer business as provided in this paragraph, then the experience of such policies must be excluded from the MLR reporting year in which it occurred and must be added to the experience reported in the following MLR reporting year."

The deferred columns in the Federal MLR reporting form disclose the deferred experience (if there is any). In the Federal MLR reporting form, the deferred experience is included in the 3/31 column of Part 1 and Part 2. The Departments find that the deferred experience is applicable to dental plans and insurers for the newer experience of dental products in each market. However, the Departments did not include the deferred column in the MLR reporting form, because it is not a routine occurrence. If any dental plan or insurer needs to report deferred experience, then it will be reported in 3/31 columns and disclosed as deferred experience in Part 5 of the MLR reporting form.

I. 12/31 Data vs. 3/31 Data

In the Federal MLR form, there are 12/31 columns and 3/31 columns under each market in part 1 and part 2. One of the purposes of the 12/31 columns is to track the amounts reported in the dental plan's or insurer's annual financial statements. Since the full service plans under the DMHC's jurisdiction already submitted the financial statements representing medical coverage to the DMHC before the Federal MLR implementation, those full service plans needed to reconcile the 12/31 column of the MLR form to the DMHC's financial statements. For plans under the DMHC's jurisdiction, the amounts reported in 12/31 columns are based on Generally Accepted Accounting Principles (GAAP). For insurers under CDI's jurisdiction, the amounts reported in 12/31 columns are based on Statutory Accounting Principles (SAP).

In the Federal MLR reporting form, the data reported in 3/31 columns is used to calculate MLR and rebate amounts. The amounts reported in 3/31columns are based on the incurred date. The amount in 3/31 columns are related specifically to experience in the 2013 MLR reporting year and paid through March 31 of the subsequent reporting year plus any provision for items properly allocable to the 2013 MLR reporting year but not yet paid as 3/31 of the following year. The Departments know that the dental claims payment cycle is much shorter than the payment cycle for medical claims. The Departments believe the industry range for full-service plans and insurers is between 18-24 months for the complete payment of medical claims due to their complexity. On the contrary, the complete payment of dental claims is much faster than medical claims, as the statutory time frame for payment is even shorter for dental plans and insurers.

However, there are still unpaid claims by 12/31 of the reporting year. Therefore, the Departments determined that collecting this data until 3/31 of the following year will yield a more accurate result for the MLR calculation. The Departments will observe the difference of the amounts reported between 12/31 columns and 3/31 columns for reporting year 2014. If the difference of the reported amounts between 12/31 columns and 3/31 columns is determined not to be material to the MLR calculation, then the Departments may consider removing the 3/31 columns in future reporting years to simplify the MLR reporting form and to reduce some administrative work for the dental and insurers.

J. Reinsurance Program

The Federal MLR reporting form and regulations make reference to reinsurance as it relates to federal high risk pools, state high risk pool, and net assumed less ceded reinsurance premium. The Departments' research does not find that dental plans and insurers purchase or participate in a reinsurance program. Thus, the Departments did not include any references to reinsurance in the MLR reporting form.

K. Health Care Quality Improvement Expenses

The Federal MLR reporting form and regulations make reference to and require detailed reporting of health care quality improvement expenses incurred by medical plans. The Departments' internal analysis determined that dental plans and insurers incur very limited amounts of dental care quality improvement expenses when compared to full service health plans and insurers. In addition, there are no defined standards and guidance regarding what constitutes health care quality improvement as it pertains to dental services. The Departments would need to define dental care quality improvement expenses to require this level of reporting. The reporting of these expenses may also result in additional administrative work for the dental plans and insurers to segregate these types of expenses. The reporting of these costs as administrative expenses will eliminate the need for dental care quality standards to be defined, maintain consistency within the industry, and result in a lower MLR calculation. The Departments determined that any health care quality improvement expenses are to be reported as an administrative expense. Thus, the Departments did not include any references to health care quality improvement expense in the MLR reporting form.

L. Experience Rating Refund

Under the Federal MLR rules, "experience rating refund means the return of a portion of premiums pursuant to a retrospective rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium." The experience rating refunds are not reported as an offset to premium, but reported as claims, according to the federal regulations. CDI uses this information to reconcile medical MLR reports against the NAIC SHCE. However, since AB 1962 does not require dental plans to submit the NAIC SHCE, it is not necessary to report these refunds in the premium section for the purpose of reconciliation. Thus, the

Departments determined that the experience rating refund amount would not be reported in the premium section, but instead would be reported in the claims section, in order to simplify the MLR reporting form and to reduce some administrative work for the dental plans and insurers.

M. Group Conversion Charges

Under the Federal MLR rules, group conversion charges are defined as the "portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance with providing evidence of insurability." This term refers to the premium and claims pertaining to providing coverage to policyholders that leave group coverage to buy individual coverage without going through an under-writing process. This type of transaction can occur when the employee wants to purchase health coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for continuation of health coverage under Health Portability and Accountability Act (HIPAA). COBRA continuation also includes dental coverage. However, none of the DMHC's full service plans reported any amount of group conversion charges in the Federal MLR reports for 2013. The Departments' internal analysis determined that it is very rare for dental plans and insurers to incur this type of coverage. The Departments did not include the group conversion charges in the MLR reporting form. If a dental plan or insurer has any group conversion charges, then the dental plans and insurers should include the experience in the direct premium and incurred claims portion of the MLR reporting form.

N. Contract Reserves

Under the Federal MLR rules, contract reserves means,

> ". . . reserves that are established by an issuer which, due to the gross premium pricing structure at issue, account for the value of the future benefits that at any time exceeds the value of any appropriate future valuation of net premiums at that time. Contract reserves must not include premium deficiency reserves. Contract reserves must not include reserves for expected MLR rebates."

Contract reserves normally apply to long-term contracts. California health plans and insurers negotiate contracts annually and are able to adjust the premium each year. Technically, contract reserves are unlikely to apply to California health plans and insurers. However, the Departments found that some full-service plans and insurers reported insignificant amounts of contract reserves in their Federal MLR reporting forms for 2013, which represented the extension of benefit. Extension of benefit means that when the enrollees' sponsor stops paying the premium, the plan or insurer is still liable for the claims payment. In that circumstance, the plan or insurer potentially pays for the enrollees' benefit without receiving any premium, which results in the plan or insurer recording contract reserves. CA Dental Plans and insurers will either not have any contract reserves experience or will have an insignificant amount of contract reserves for

dental coverage. Thus, the Departments did not include contract reserves in the MLR reporting form. If a dental plan or insurer has any contract reserves, then the plan or insurer should include it in the incurred claims or claim reserves portion of the dental MLR reporting form.

O. Health Care Receivables

The Federal MLR reporting instructions for claims specifically provide that claims paid include "any overpayment that has not yet been recovered should be included in paid claims and included in health care receivables". The Departments believe that dental plans and insurers are less likely to overpay a provider for dental services as dental claims are usually less complex. If a dental plan or insurer has any health care receivables, then the plan or insurer should include them in the claims portion to offset the claims expenses in the MLR reporting form.

P. Blended Rate Adjustments

Under the Federal MLR rules, blended rate means "a single rate charged for health insurance coverage provided to a single employer through two or more of an issuer's affiliated companies for employees in one or more States." In addition, the Federal MLR rules states that,

> ". . . affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula that must be defined by the issuer prior to January 1 of the MLR reporting year, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate."

Blended rates arise when two affiliated companies under the DMHC and CDI offer the same type of products to the same employer group; the two affiliated companies may offer blended rates. Two of the DMHC's full service plans reported an amount of blended rate adjustment in the Federal MLR report form for 2013. Both of these plans have grand-fathered PPO products under the DMHC and they may have affiliated companies that are regulated by CDI that also have PPO products. While the Departments find that blended rates may be applicable to dental plans and insures that have affiliated companies under both regulators and offer the same type of product to one employer group, the Departments also understand that it is not likely that an affiliated company that offers group coverage at a blended rate would choose to make an adjustment to each affiliates' incurred claims. As results, the Departments did not include the blended rate adjustments in the MLR reporting form.

Q. Fraud Reduction Expenses

The Federal MLR rules and reporting forms require full service plans and insurers to report any expenses related to fraud reduction. The Departments' internal analysis determined that dental plans and insurers spend insignificant amounts for fraud reduction expenses when compared to full service health plans; and such expenses are reported as an administrative expense. The Departments' review of the 2013 Federal MLR reporting forms for full service plans indicates that they spend an insignificant amount for fraud reduction expense and it did not materially impact the MLR calculation. As a result, the Departments determined that any fraud reduction expenses will be treated as administrative expenses for MLR reporting purposes. Thus, the Departments did not include the fraud reduction expenses in the MLR reporting form. This decision will simplify the dental MLR reporting form and reduce administrative work for the dental plans and insurers.

R. Credibility Adjustments/Credible Experience

The Federal MLR rules and reporting forms address credibility adjustments that pertain to the smaller full service plans that may experience high variation of claims experience due to the in-frequent number of large-dollar claims. The Departments believe that the dental plans' and insurers' claims do not experience as much variation as the claims of full service plans and insurers, due to the fact that majority of the dental products have maximum benefit limitations of $1,000-$2,500. As such, the dental plans' and insurers' claims expenses are more predictable. Accordingly, the Departments believe there is no need for the credibility adjustment and did not include the credibility adjustment in the guidance or the MLR reporting form. In regards to the pediatric dental product, there is no benefit limitation. However, the Departments will observe the variation of pediatric MLR and growth of the pediatric line of business to be disclosed in the MLR reporting form and determine if a credibility adjustment is required in future reporting periods.

The Federal MLR rule states that health plans or insurers with less than 1,000 life-years will not gain credible experience to determine whether the health plans or insurer met the MLR requirements. Thus health plans or insurers with less than 1,000 life-years are considered to meet the MLR requirements and will not pay any rebates. The Departments will consider dental plans or insurers with less than 1,000 life-years to have non-credible experience. Therefore, dental plans or insurers with less than 1,000 life-years are not required to calculate the MLR.

The federal MLR rule states that in calculating MLR, the health plans are required to aggregate the data for three (3) years. Dental plans or insurers who have non-credible experience in the first year may have credible experience in the second or third year. Therefore, dental plans or insurers with non-credible experience are still required to fill out the MLR reporting form.

S. Instructions for Reporting

Some stakeholders recommend adding to the instructions the list of items to be included under "reimbursement for dental clinical services provided to enrollees" be consistent with the guidance and to make it clear that capitation payments to dentist are included as incurred claims. The Departments will incorporate the list of reimbursement for dental clinical services provided to enrollees in the reporting instructions.

T. Removal of Part 1 Lines 5.1-5.4 (enrollment information), 6 (Net investment income and other gain/loss) and 7 (Other Federal income taxes) from Report Form and Instructions for Reporting

Some stakeholders recommended removing Part 1 lines 5.1to 5.4, 6, and 7 as not relevant to the calculation of MLR. In order to be consistent with the federal MLR form, the Departments will keep Part 1 Lines 5.3 to 5.5, 6 and 7. The Departments removed Part 1 lines 5.1 and 5.2 due to the fact that the dental plans and insurers are not tracking the number of policies/certificates and number of groups.

U. Definition of Small Group

Some stakeholders indicated that dental plans or insurers do not differentiate between individual and small group markets. Thus some dental plans or insurers do not track this enrollment information separately. In discussion with stakeholders, it was agreed that starting in the 2016 reporting year, all dental plans or insurers are to track individual and small group markets separately.

In year 2014 reporting form, small group is defined [Health and Safety Code section 1357(l)(1), Insurance Code section 10753(q)(1)(A)] as "any person, firm, proprietary or nonprofit corporation, partnership public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two (2), but not more than 50, eligible employees." For reporting year 2014, health plans or insurers are not required to make a determination of which employees are "eligible" employees for the purpose of determining whether the definitional requirement for small employer (2 to 50) is satisfied.

V. Employment Tax

According to the Federal MLR regulation, effective 2016, employment tax is not allowed to be deducted from premium in calculating MLR. Some stakeholders indicated that such change was not reflected in the MLR instruction and reporting form. However, as required by AB1962, the Departments are basing the current form on the 2013 federal MLR instruction and reporting form, which is not affected by the treatment of employment tax.