BACKGROUND: California bill AB1962 aims to extend an ACA-style minimum loss ratio (“MLR”) requirement to dental health care service contracts and dental health insurance policies in the state. Dental plans offering coverage in the large group market would be subject to a minimum loss ratio of 85%, while dental plans in the small group or individual market would be subject to an 80% minimum loss ratio.

NADP has been engaged with the California Association of Dental Plans (CADP) in opposing the measure given the potential for a California enactment spreading to other states or to the federal level. Despite substantial opposition AB1962 has been reported from the Assembly Health Committee and is scheduled for a hearing in Assembly Appropriations on April 30th. Because of the fiscal implications in the cost of regulation and increased premiums to state groups, the bill will be held in a “suspense” mode for a few weeks past this hearing. While CADP’s new lobby team and the cadre of company lobbyists that are part of the team on the ground have raised substantial doubts about the level of loss ratio contained in the bill, a combination of factors may make the bill difficult to stop. The lobby team reports that our best leverage for a compromise is during the suspension period in Appropriations.

NADP was asked to prepare some method for dental plans to provide input to a potential compromise on the bill. This includes not only what loss ratio targets are reasonable, but how the loss ratio calculation is made. NADP engaged Milliman to examine the ACA’s medical loss ratio calculation and advise us on its elements so that some decisions could be made with regard to a proposed compromise. After joint discussion with Milliman and a small group of CADP and NADP members we have developed the attached calculator with explanations to be used by members in examining their latest year’s results (2013) under a proposed formula. In each section of the calculation, the inputs for that section are described.

ACTION REQUIRED: It is critical that members use this calculator to provide feedback by April 30th to help shape the industry compromise on AB1962. Please direct questions on the calculator to Jerry Berggren, NADP’s Director of Research at 972-458-6998 x109 or jberggen@nadp.org.

Description of Differences in ACA’s MLR, Traditional Loss Ratios and Proposed Formula: The ACA loss ratio calculation is modified from the traditional “claim costs divided by premium” loss ratio, allowing specifically defined quality improvement expenses (QIE) to be included in the numerator and taxes and fees to be subtracted out of the denominator. If the ACA minimum loss ratio requirements are not met, insurers must provide an annual rebate to enrollees.

The QIE expenses that are included in the numerator for medical plans have been specifically defined by federal rules. Given the definitions, there seem to be few, if any, QIE expenses that could be added by dental plans to a dental loss ratio calculation. The medical QIE expenses are generally classified as those expenditures for activities conducted by an issuer that:
• improve health quality
• increase the likelihood of desired health outcomes in measurable ways
• are directed toward individual enrollees or incurred for the benefit of the enrolled population
• are grounded in evidence based medicine and clinical best practices, and

Some activities are expressly prohibited from being counted as QIE, including those that are:
• primarily focused on containing cost
• benefit self-funded plans
• paid for with revenue other than premiums
• reimbursable to providers as clinical services
• concerned with maintaining claims adjudication systems
• concerned with retrospective or concurrent utilization review, or
• involve developing or executing provider contracts, maintaining provider networks, or credentialing providers

Initial Construct for Dental Loss Ratio: The NADP/CADP Working Group is proposing that a dental loss ratio include only claims costs in the numerator with taxes, fees and external commissions subtracted from the denominator. We are also advocating for an initial implementation year of 2016 which is the year that the ACA requires the small group to be defined as 100 or fewer employees. This prevents having to implement a loss ratio for one year on the group size of 50 only to change the size the following year.

Because of the large segment of dental plans in California with DMHO products which have substantially lower premiums, the Working Group’s initial belief is that there should be separate loss ratio targets for DHMO and DPPO products in addition to separate targets for individual/small group and large group segments. Your feedback on this survey will help us determine if our belief is accurate. So for the purposes of the calculator, we need your feedback for these market segments:

• Small Group DHMO
• Large Group DHMO
• Small Group DPPO
• Large Group DPPO
• Individual
• Small Group Indemnity
• Large Group Indemnity

The loss ratio calculation should control for the significant variability in agent commissions between market segments. So, the calculation will need to be done both with agent commission removed from the denominator and with the agent commission in the denominator. The primary argument for removing commissions is that as a low cost, voluntary product, agents’ commissions are less malleable in a dental plan than they would be in a medical plan.

As a starting point in negotiations, we are proposing that rebates to individuals be eliminated as the enforcement mechanism for a plans’ failure to meet the dental minimum loss ratio. Rebating is unduly burdensome under the ACA construct for low premium dental plans. The MLR is calculated at the enterprise level but every employee covered by the rebating carrier in a line of business is to receive a rebate based on their level of contribution to their coverage. The level of contribution is usually not known by the carrier. So federal rules allow the medical carrier to provide a rebate to each employer who then distribute the rebate to employees under some standard distribution guidelines. This process would likely cost dental carriers more than

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1 Dental plan rebates would likely fall under the “de minimis” exception in federal rules for payment of medical plan rebates.
the rebates themselves, further increase administrative costs and lower future loss ratios—a true downward death spiral.

We are examining a series of alternatives to the individual rebate that could encompass a prospective regulatory rate review adjustment to a carrier’s book of business, or a lump sum payment to a governmental agency that would use the funds for oral health purposes, i.e. Medicaid, CHIP or Covered California. (Perhaps rebates could fund state subsidies for pediatric dental coverage and allow dental plans back in CC.)

The proposed calculation for a Dental MLR is

Dental Claims Cost by Line of Business & Group Size
Premium (by Line of Business & Group Size) minus Taxes/Fee and External Agent Commissions

See the attached Excel spreadsheet for instructions on executing the calculation to provide your feedback to NADP.

NOTE: The Dental MLR calculation will be made on an enterprise wide basis for both California and your nationwide total book of business. If you have business in California, respond for your California blocks of business and your total national blocks of business. If you do not have business in California, provide your enterprise wide information on a national basis.

Other Things You May Want to Know About the ACA MLR Calculation and the Dental MLR Proposal

The MLR description in the ACA is short but there are several hundred pages of regulations implementing it. These regulations have been refined over the years since MLR was implemented for medical plans.

Regulations: MLR was put into effect in 2011 and initial interim regulations were not promulgated until December 2010. MLR rules were finalized a year later in December of 2011. Medical plans were given until June of the following year (2012) to calculate MLR thus allowing a full calendar quarter (through the end of March) for run-off of claims on the previous year. Rebates were then paid in August of 2012.

Health plans with small books of business in any market segment (i.e., Individual, Small, Large) received a credibility adjustment that ranged from 0% to 8.3%, with segments under 1,000 lives being exempt from MLR and segments with over 75,000 lives receiving no credibility credit. Additional credit was given to segments that had high average deductibles. The credibility adjustment was intended to protect plans from paying rebates due to statistical volatility alone, i.e. volatility driven by small membership and deductible leveraging.

The credibility adjustment was a short term patch in implementation that was used until a 3 year rolling “look back” was developed for medical plans. And the credibility adjustment could not be taken when a plan failed to hit the MLR for 3 years in a row.

Take Away: Regulations developed by a single state will require substantial effort and input that was provided by NAIC, HHS, and national associations like AHIP for MLR. Analytical work will need to be performed to identify appropriate credibility adjustments appropriate for dental plans.

Failure Rates: In the first year of results—after credibility adjustments, 37% of carriers with individual blocks of business, 17% of carriers with small group blocks of business and 11% of carriers with large group blocks of business failed the MLR. In 2012 failure rates were reduced to 25% in the individual
market segment and 6% in the large group market segment but remained at 17% in the small group market segment.

**Treatment of Non-Profits:** Non-profits were exempt from MLR in the first few years while regulations were developed. One issue in establishing a level playing field in the MLR formula for non-profits was how to treat required community benefit expenditures that are made in lieu of paying taxes. As the treatment of these expenditures can vary widely by jurisdiction, the method of incorporating them into the MLR formula was difficult to construct. Similar issues could arise for dental non-profits.

**Exemptions from Rebating:** Federal rules provide a precedent for HHS being concerned with the administrative burden of paying small rebates. Accordingly, HHS implemented de minimis rules (e.g., $20 to an employer or $5 to an individual policyholder) that allowed the rebates for specific small policies to be aggregated and spread to other contracts. In addition, HHS ultimately gave health plans some safe harbors for how to deal with paying rebates to employer groups that ameliorated some of the complications of getting rebates to individual employees according to their contributions through payroll, tracking down lapsed employees, and other issues. HHS also required different rebate disbursement methods for MEWA trusts and for government employer sponsored plans.

**Phase in Allowances for Individual Policies:** There is also a precedent in federal rules for slower phase-in of MLR where market disruption would likely occur. When the health MLR was rolled out, HHS allowed states to request waivers of the MLR in the Individual market only. Seventeen states and a territory applied for waivers and seven states were granted an adjustment. For the most part, the waivers were granted as three year phase-ins to the Individual market MLR standard of 80%.

**Table 3. HHS Individual Insurance Market Waivers**  
Alternative MLRs for states that received waivers from 2011-2013.

<table>
<thead>
<tr>
<th>State</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>70%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>Iowa</td>
<td>67%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>75%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Maine</td>
<td>65%</td>
<td>65%</td>
<td>65%a</td>
</tr>
<tr>
<td>Nevada</td>
<td>75%</td>
<td>NAb</td>
<td>NAb</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>72%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>75%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Source:** HHS. For more detail on individual state waivers and applications go to [http://ccio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html](http://ccio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html).

a. Third year depends on data submission.

b. Nevada asked for only a one-year waiver.

**Situs:** For group coverage issued by a single issuer that covers employees in multiple States, federal rules on MLR require employees to be attributed to the applicable State based on the situs of the contract. Group coverage issued by multiple affiliated issuers that covers employees in multiple States must be attributed by each issuer to each State based on the situs of the contract.

The explanation that accompanied the rules indicates that the regulation requires issuers to report experience based on the State-of-issue for each policy that it writes. This requirement is intended to
result in a report that describes experience under policies whose benefits and premiums either are regulated, or could be regulated, by a State, since it is at the State level that insurance regulation occurs. The regulation generally defines the State-of-issue based on the “situs” of the insurance contract between the issuer and the policyholder. HHS defines “situs” as the State in which the contract is issued or delivered as stated in the contract. Consistent with NAIC guidance, HHS interprets this as the State that has primary jurisdiction over, or governs, the policy.