Loss Ratio Regulations for Dental Plans
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Agenda

- Potential for Dental Loss Ratio Regulations
- California AB1962 – Lessons Learned
- Considerations for Applying ACA Loss Ratio Regulations to Dental
- Loss Ratios in the Dental Industry
- Questions
Loss Ratio Basics: ACA Loss Ratio

\[
\text{ACA Loss Ratio (ACA LR)} = \frac{\text{Claim Cost + Quality Improvement Expenditures}}{\text{Premium – Taxes, Licensing, and Regulatory Fees}}
\]

- Numerator includes expenditures on quality improvement (subject to rules and documentation)
- Premium may be reduced by specific taxes and fees
- **Carriers are required to issue rebates** to enrollees if percentage doesn’t meet minimum standards of 80% *(individual and small group)* or 85% *(large group)*
- **Dental is exempt** from the ACA LR provisions

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Other Important Characteristics

- Does not allow a deduction for commissions (treated just like admin and profit to the insurer)
- Involves a complicated formula on a rolling three-year window
- “Credibility Adjustment”: Smaller plans may add points to their MLR
- Level of granularity is: Small/Large/Indiv, no cross-subsidy
- De Minimis rules allow pooling of small rebates ($5-$20)
- Challenge of how to allocate rebates to employees within employer plan

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Why Is Dental Exempt from ACA Medical Loss Ratio Rule?

- Dental is an “excepted benefit” under ACA
- Recognition that some aspects of ACA don’t make sense for dental plans
- Prevailing loss ratios for dental plans are different than for medical plans
- For standalone dental, the postage and the processing would cost more than the value of the rebate

California’s AB 1962

- California came close to implementing the first dental loss ratio law based on precedent from the ACA medical loss ratio law, and would have:
  - 80% minimum in small/individual market; 85% large
  - Require annual rebates payable to policyholders
  - Most other characteristics of ACA MLR regulations would be applied
  - However, final bill required reporting of loss ratios only

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Why do we care about the precedent of AB1962?

- Other states may introduce regulations like the early drafts of AB1962
- AB1962 used characteristics and parameters from the ACA MLR regulation that may not be appropriate to the Dental market (more to follow)
- Gathering information now about the Dental market can help communicate these issues to State legislators

Level of Granularity

- ACA MLR precedent is to use Individual / Small Group / Large Group
- It may be more appropriate to split Dental into HMO vs. PPO and Indemnity
- Smaller granularity will also drive higher volatility year over year. There is precedent to include credibility adjustments, which add points to the loss ratio for small plans
Minimum Loss Ratio

- The 80%/85% standards for health plans under ACA are not comparable to prevailing loss ratios in the Dental market.
- On the health side, in the first year, approximately 1/3rd of Individual market received rebates, 17% in Small Group, and 11% in Large Group, 16% overall.
- In second year, fell to 25% for Individual, 17% for Small Group, and 6% for Large Group, 11% overall.
- Setting the Dental minimums to meet similar rebate rates (i.e., 10% range) may be more appropriate than simply copying the minimums from the health side.

Components of the Formula

- Commissions are a much larger driver of non-claims expense as a percent of premium than on the health side and vary significantly by market. The health formula does not control for commission differences.
- Quality Improvement Activities are part of the numerator in the health formula and were an important addition for the health industry; however, this may not be as important for dental, too much reporting work for too small of an adjustment.
- Numerous other details in health formula may be too burdensome to gather and report on the dental side.
Administrative Burden

- Reporting requirements for the MLR calculation may be significant for Dental plans.
- Plans may find that they are paying very small rebates. On the health side, HHS already recognized that $5 was de minimis for Individual rebates and $20 was de minimis for group rebates.
- One could argue that this precedent for de minimis would likely apply to a majority of rebates under a Dental MLR rule.

Industry Info on Dental LRs


<table>
<thead>
<tr>
<th>Provider Payments</th>
<th>DHMO % of Total Premium</th>
<th>DPPO % of Total Premium</th>
<th>Dental Indemnity % of Total Premium</th>
<th>Total % of Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>12.68%</td>
<td>11.49%</td>
<td>10.89%</td>
<td>12.05%</td>
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<tr>
<td>Sales and Marketing</td>
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<td>Taxes, Interest &amp;</td>
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<td>7.93%</td>
<td>2.14%</td>
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<td>Goodwill</td>
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<tr>
<td>Profit/Surplus or</td>
<td>8.75%</td>
<td>4.41%</td>
<td>2.06%</td>
<td>5.00%</td>
</tr>
</tbody>
</table>

- Actual proportion of premiums spent on provider payments well below 80%/85%.
- Individual and small group loss ratios lower than large group.
Recommended Market Analysis

- Summarize claims, premiums, commissions, life years for each line of business, for each company in the market
- Use the small/large/individual granularity that is from the ACA MLR precedent
- Alternatively add a DHMO vs. DPPO/Indemnity breakout to the above
- Review the distribution of loss ratios across plans and “levels of granularity” in the market.
- Review alternate formulas (e.g., w/ and w/o deduction for commissions)

Recommended Market Analysis (cont.)

- Evaluate the # of plans that could fail the minimum loss ratio test
- Evaluate the magnitude of rebates payable under different loss ratio minimums
- Consider cost of paying rebates
- Consider what a reasonable minimum loss ratio could be under that criteria that x% of plans would fail it each year
- Use this analysis to evaluate legislative proposals
Industry Info on Dental LRs

- NAIC minimum loss ratio standards
- Standard for “reasonableness of benefits in relation to premiums”
- Different minimum loss ratios based on the renewability requirements for the coverage
  - Guaranteed Renewable medical policies: 55%
- Formulaic adjustment to LR for low premium policy forms (like dental) – lowers the LR requirement
- Many states have implemented NAIC standards, some with variations

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