SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 1008
AUTHOR: Skinner
VERSION: April 10, 2018
HEARING DATE: April 25, 2018
CONSULTANT: Teri Boughton

SUBJECT: Health insurance: dental services: medical loss ratios: out-of-network coverage information: disclosures.

SUMMARY: Establishes medical loss ratios for dental health plans and health insurance policies of 75% for large group products and 70% for small and individual market products; requires dental health plans and health insurance policies to utilize a uniform benefit disclosure form, as specified; and, requires dental health plans and health insurance policies that cover out-of-network dental services to provide specified information on behalf of the enrollee or insured related to covered services, criteria and procedures for treatment and payment decisions, as specified.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurance. [HSC §1340 et seq. and IC §106 et seq.]

2) Requires every health plan and health insurer that issues, sells, renews, or offers health plan contracts or insurance policies for health care coverage, including a grandfathered health plan or insurer, but not including specialized health plan contracts or insurance policies, to provide an annual rebate to each enrollee under such coverage if the ratio of the amount of premium revenue expended by the health plan or insurer on the costs for reimbursement of clinical services provided to enrollees or insureds, as specified, to the total amount of premium revenue less certain taxes and fees is less than the following:

    a) 85% for a health plan or health insurer in the large group market; or,
    b) 80% for a health plan or health insurer in the small group or individual market. [HSC §1367.003 and IC §10112.25]

3) Requires DMHC and CDI to require health plans and health insurers to disclose specified information to the public, subscribers, and enrollees with a full and fair disclosure of plan or policy information in readily understood language in a clearly organized manner. [HSC §1363 and IC §10603]

4) Requires a uniform matrix for small and individual market products to include specified category descriptions together with corresponding copayments and limitation in a sequence that includes such categories as deductibles, lifetime maximums, professional services, outpatient services, hospitalizations, and others, along with a statement that the matrix is intended to help compare coverage benefits and is only a summary, as specified. [HSC §1363 and IC §10603]

5) Permits a health plan contract or insurance policy subject to the Affordable Care Act (ACA), as specified, to satisfy the requirements of 4) above by providing the uniform summary of

benefits and coverage required under the ACA, and applicable benefit disclosure requirements and other notices required in state law and regulation. [HSC §1363 and IC §10603]

6) Requires, commencing July 1, 2019, a Medi-Cal managed care plan to comply with a minimum 85% medical loss ratio (MLR) or pay a remittance consistent with federal regulations. Applies the remittance requirement to Medi-Cal managed care plans but not primary care case management plans (PCCMs), dental plans, county mental health plans or Drug Medi-Cal Organized Delivery Systems. [WIC §14197.1 and §14197.2]

This bill:

1) Requires a health plan or health insurer that issues, sells, renews, or offers a specialized health plan contract or health insurance policy that covers dental services in California, in addition to other applicable disclosure requirements, to utilize a uniform benefit disclosure form, developed by DMHC or CDI. Requires at a minimum, the form to provide the following:

   a) The annual overall plan or policy deductible;
   b) The annual benefit limit;
   c) Coverage for preventive and diagnostic services, basic services, major services, and, orthodontia services;
   d) Dental plan or policy reimbursement levels, including estimated enrollee or insured cost share;
   e) Estimated annual out-of-pocket expenses;
   f) When the disclosure form is updated, the applicable MLR for the prior year; and,
   g) Limitations, exceptions, and waiting periods.

2) Requires a health plan that issues, sells, renews, or offers a specialized health plan contract that covers dental services in this state and that offers a dental discount product, in addition to any other applicable disclosure requirements to fully disclose on the plan's Website and on the disclosure form required by 1) above, the type of discount product that the purchaser will receive. Requires DMHC to consult with stakeholders to determine the specific disclosure language.

3) Requires DMHC and CDI to adopt emergency regulations to implement 1) above, as specified, and requires DMHC and CDI to consult with each other, as appropriate. Exempts the regulations from being subject to review and approval from the Office of Administrative Law, as specified.

4) Requires a health plan or health insurer that issues, sells, renews, or offers a specialized health plan contract or health insurance policy that covers dental services, including a grandfathered health plan or health insurance policy, but not including a dental discount plan or dental discount product, to provide an annual rebate to each enrollee or insured under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health plan or insurer on the costs for reimbursement for clinical services provided to enrollees or insureds under that coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

   a) 75% with respect to a health plan offering coverage in the large group market; and,
   b) 70% with respect to a health plan offering coverage in the small group and individual market.

5) Permits DMHC and CDI to adopt emergency regulations according to the Administrative Procedure Act to implement the MLR requirements in 4) above.

6) Defines dental discount plan as a membership-based discount plan for dental maintenance and intervention, licensed by DMHC, in which the referring company does not assume financial risk and the patient pays the entire cost of a rate negotiated between the dentist and the referring company.

7) Defines dental discount product as a discount dental services product offered under a specialized health care service plan contract that covers dental services.

8) Amends existing law that requires an annual MLR report on health plans or health insurers that issue, sell, renew, or offer a specialized health plan contract or health insurance policy covering dental services to be filed with DMHC or CDI by September 30 each year to instead be filed by July 1 of each year, and requires DMHC or CDI to post the information on their Internet Websites within 45 days after receiving all MLR annual reports.

9) Requires a health plan or health insurer that issues, sells, renews, or offers a specialized health plan or health insurance policy that covers dental services and provides out-of-network dental services as a covered benefit to provide a billing and treating provider, on behalf of the enrollee or insured, all of the following:

   a) The health plan's or insurer's criteria and procedures for deciding whether to provide or deny payment for or coverage of dental procedures or treatment;
   b) The dental treatment and procedures covered; and,
   c) The actual percentages or amounts payable as a benefit toward dental care or treatment, including an explanation of benefits or other notification of payment issued by the plan or insurer on behalf of the enrollee or insured for dental treatment rendered by the billing provider.

10) Exempts Medi-Cal dental managed care plan contracts from 9) above.

11) States legislative intent to enact legislation, by 2024, to incrementally increase the minimum MLR applicable to specialized health plans and health insurance policies that cover dental services, as specified, until these ratios are equal to the minimum MLR that are applicable to other health plans and health insurers.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* This bill improves transparency and assures value for consumers by holding dental plans accountable to comparable standards as medical plans. The ACA requires medical insurance plans to adhere to a "MLR" standard that ensures they spend no less than 80% of premium dollars on patient health care, rather than on administrative overhead and profits. While this consumer protection exists for medical plans, there is no

standard for assuring value in dental insurance. Plan-reported data shows wide variation in "dental loss ratios" (DLR) across plans, with some plans spending as low as four percent on patient care. Establishing a DLR standard is a logical step to ensure better value in dental insurance. Furthermore, this bill provides greater transparency to help consumers make informed decisions about their dental insurance. Currently, there is no standardized benefit reporting form, like that which exists for medical insurance. Benefit information may be spread through long documents that make it difficult for consumers to compare plans. Additionally, consumers often have difficulty discerning the difference between dental insurance plans and dental discount plans, which do not offer insurance. This bill requires disclosures and standardized benefit reporting to help consumers understand what they are purchasing.

2) *Medi-Cal MLR*. The Medicaid managed care rules issued by the federal Centers for Medicare and Medicaid Services (CMS) in 2016 and early 2017 permits states to require Medi-Cal managed care plans to meet a minimum MLR, provided the minimum MLR is equal to or higher than 85% (the standard used for projecting soundness). In addition, the rule gives states the option of requiring a remittance if plans do not meet the MLR, which SB 171 (Hernandez, Chapter 768, Statutes of 2017) implements (except for dental managed care plans and PCCMs). Dental managed care plans were exempt from the remittance because of a concern that the standard could not be met by many plans. Prior to the federal rule, California did not impose a MLR on full-service Medi-Cal managed care plans, except for a federally required MLR for the Medicaid optional expansion population. California had also previously contractually required dental "minimum" loss ratio for dental managed care plans of 70%.

3) *ACA MLR*. The ACA requires states to establish an MLR for health plans serving commercial populations. Dental plans are exempt from the ACA-required MLR. For plans in the large group market, the ACA-required MLR is 85% or a higher percentage determined by the state through regulation. For individual and small group plans, the MLR is 80% or a higher percentage determined by the state through regulation. The federal Department of Health and Human Services (DHHS) Secretary can adjust small group and individual market MLR if he or she determines that the 80% requirement may destabilize the individual market in a state. If a plan fails to meet the federal MLR requirements, rebates are required to be issued to the plans' customers. Rebates from the ACA-required commercial MLR (reported to DMHC), indicates, from reporting year 2011 through 2015, ten plans have issued rebates in the following dollar amounts: individual market: $64 million; small group market: $138.2 million; and, large group market: $3.3 million. A recent CMS final rule for 2019 allows states to request reasonable adjustments to the MLR standard for the individual market if the state shows a lower MLR standard could help stabilize its individual insurance market.

4) *DLR Reports*. The California Dental Association (CDA), the sponsor of this bill, compiled DLR data self-reported by dental insurers and health plans required by AB 1962 (Skinner, Chapter 567, Statutes of 2014). The chart shows the range of data in CDA's document.

	Individual HMO	Individual PPO	Small HMO	Small PPO	Large HMO	Large PPO
2014, 2015, 2016	-9.24 to 91.32%	12.90 to 126.14%	3.72 to 157.81%	21.59 to 111.85%	41.80 to 85.70%	27.91 to 129.23%

DMHC released a consolidated overview of 19 dental plans reporting under AB 1962 for 2016, with Average HMO MLRs by market for 2016 are: individual 43%; small group 55%; and large group 63%. Average PPO MLRs are: individual 66%; small group 61%; and large group 87%. Additional data in DMHC's consolidated overview are in the chart below.

Covered lives	% of Overall Dental Plan Enrollment	MLR	Administrative Cost Ratio (range)	Profit Margin (range)
4,378,714	73.6%	70-87%	11-41%	-1-10%
1,033,718	17.4 %	61-67%	23-61%	-19-26%
503,267	8.5%	50-58%	31-102%	-57-15%
29,597	.5%	4-40%	24-49%	7-49%
	Average	**58%**	**41%**	**6%**

A Milliman report of available data states that minimum dental MLRs can have significantly different effects by size and product segments; and significant changes would be required for individual HMO products, currently averaging a 60.6% dental MLR, to meet a 70% minimum dental MLR, compared to large group PPO products, currently averaging 86.1%. The Milliman report indicates that to the extent carriers target an average profit margin across several lines of business or case size segments, a minimum dental MLR which forces the margins to decrease in one segment may cause carriers to raise margins in another segment not constrained by the minimum dental MLR. Carriers with blocks of business with higher volatility (e.g., highly concentrated in the individual market) may begin to make product or financing changes at a higher profit than five percent, while others may be able to live with profit lower than five percent before resorting to such changes.

5) *Summary of Benefits and Coverage*. Under the ACA, health insurers and group health plans are required to provide individuals with private insurance clear, consistent and comparable information about their health plan benefits and coverage. Under the law, insurance companies and group health plans provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document helps consumers better understand the coverage they have and, allow them to easily compare different coverage options. It summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan. The benefits and coverage information is specific to health benefits and coverage, and does not include dental benefits and coverage information.

6) *Discount health plans*. According to an undated DMHC fact sheet, beginning in 2004, DMHC began to crack down on discount health entities, issuing a Consumer Alert in both English and Spanish on the DMHC Web site, taking enforcement actions and publicizing the issue through the media. DMHC ordered 17 fraudulent discount health card companies to cease operations or become licensed. One full-service medical plan and two dental plans became licensed. DMHC was poised to become one of the first states in the nation to introduce regulations to license discount health entities. In 2006, an administrative law judge ruled that the DMHC had jurisdiction over discount card companies because they are arranging for the provision of health care services in exchange for a periodic payment. This

precedential decision confirmed that these companies are acting as health plans and therefore, must be licensed by the DMHC. DMHC's regulations were to have full consumer protections such as strict advertising restrictions, measurable discounts, verifiable provider contracts and uniform cancellation policies. A preliminary draft of DMHC's regulations defined discount health plans as a "a person that, in exchange for a prepaid or periodic charge, paid by or on behalf of subscribers and enrollees, arranges for the provisions of access to health care services and products at rates that are discounted from the usual prices charged by health providers, and for which the subscriber or enrollee retains the financial responsibility to pay the provider for the discounted services rendered." These regulations were never finalized.

7) *Related legislation*. AB 2499 (Arambula) increases the minimum MLR percentages applicable to health plans and health insurers by five percent, as specified. *AB 2499 passed out of the Assembly Health Committee on April 10, 2017 by a vote of 10-4*.

8) *Prior legislation*. AB 1962 requires a health plan or insurer that issues, sells, renews, or offers specialized dental plans or policies to file an annual report with appropriate state regulators that are organized by group and product type and contain the same MLR information required to be reported by health plans and insurers under the federal ACA.

   SB 171 among other requirements requires, commencing July 1, 2019, a Medi-Cal managed care plan to comply with a minimum 85% MLR consistent with federal regulations. Applies the remittance requirement to Medi-Cal managed care plans but not PCCMs, dental plans, county mental health plans or Drug Medi-Cal Organized Delivery Systems. Requires, effective for contract rating periods commencing on or after July 1, 2023, a Medi-Cal managed care plan to provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85%. Requires DHCS to determine the remittance amount on a plan-specific basis for each rating region of the plan and to calculate the federal and nonfederal share amounts associated with each remittance.

   SB 51 (Alquist, Chapter 641, Statutes of 2011) establishes enforcement authority in California law to implement provisions of the federal ACA related to MLR requirements on health plans and health insurers and prohibitions on annual and lifetime benefits.

   AB 2855 (Parra of 2006) would have made it unlawful for a person to engage in business as a discount health plan, as defined, unless the person was licensed by DMHC. The bill would have required DMHC to adopt regulations, on or before July 1, 2007, to license and regulate discount health plans, and would have required DMHC to report to the Legislature on certain matters on or before January 1, 2009. *AB 2855 never had a hearing in the Assembly Health Committee*.

   AB 562 (Levine of 2005) would have required DMHC to develop a registration process for discount health programs, as defined and establishes requirements for the operation of these programs, subject to DMHC enforcement. *AB 562 was held in the Assembly Appropriations Committee*.

   AB 1091 (Parra of 2005) would have established requirements for discount health care programs (discount programs) including provisions related to contracts with providers, marketing, requiring a toll-free telephone number and registering with DMHC. *AB 1091 was held in the Assembly Appropriations Committee*.

9) *Support*. CDA writes that three years of dental plan reporting demonstrated a wide variation in DLRs by product type and market, with plans falling as low as four percent spent on patient care, raising significant questions about the consistency and value of plans. The average DLR in 2014-15 in California was 61%, considerably lower than the 76% reported nationwide. The average DLRs range from 52% for individual plans, 60% for small group plans and 72% for large group plans. The plan-reported data validates that too much of dental plan premiums are spent on administrative overhead costs and not enough is spent on patient care. CDA writes that this bill seeks to level the playing field for consumers and providers by holding dental plans accountable to comparable standards as medical plans. This bill preserves the integrity of the provider-patient relationship and patient freedom of choice, while allowing for effective and efficient oral health care. Having dental coverage helps consumers defray the cost of dental treatment, and dental premium dollar expenditure disclosure and access to clearly defined benefit, limitations and exclusions, deductibles, co-payments and coinsurance are all factors that influence patient choice in their selection of a dental benefit plan. Californians deserve adequate value from their dental benefit coverage and the same protections currently applicable to their medical plans. The Western Center on Law and Poverty writes that there is no standard for assuring value in commercial dental benefit plans, leaving purchasers with little information on how their dental premium dollars are spent. A DLR helps ensure a minimum value for consumers and holds insurance companies accountable for how they are spending patients' premium dollars. Seniors and other individuals purchasing dental plans on Covered California have reported purchasing these dental policies and receiving no benefit from them. This bill holds dental plans accountable and helps consumers make informed decisions.

    Health Access California writes that since 2014, dental plans have been required to report their DLR to DMHC. For annual reporting year 2016, the data shows the 19 different health plans licensed by DMHC had a great variance in the DLR from four percent to 87%. The lack of a DLR standard has led to significant variation amongst the dental plans, raising concerns that consumers are paying too much for a dental plan that does not cover what they need. Health Access has long supported establishing a DLR to assure that dental plans offer coverage of value, and coverage for adult dental benefits is different than medical coverage in that it is not required to cover medically necessary dental care and can include annual dollar limits on benefits covered ($1,000 or $2,000 per year). This bill would establish a DLR that appropriately considers how dental coverage differs from medical plans, which have a higher MLR standard. The proposed standard in this bill ensures most of the premium dollar goes towards actual care rather than overhead costs or profits of the dental plans.

10) *Opposition*. The California Association of Dental Plans (CADP) writes this bill would dramatically disrupt the dental insurance market in California, leading to substantially higher premiums and loss of coverage under the guise of a loss ratio standard. This bill actually just increases plan payments to dentists. CADP believes that the combination of an inappropriate dental MLR and the imposition of new regulatory requirements will drive plans out of the California market resulting in less consumer choice and force premium increases for the remaining plans in the market. CADP indicates that specific to dental MLR, 30% to 40% increases could be required in dental HMO premiums to reach the proposed dental MLR. CADP also writes that requiring plans to use a uniform benefits disclosure form further increases administrative costs to plans and the dental discount definitions are unclear and require greater analysis. With regard to the out-of-network disclosure requirements, it is information that is already available to providers and consumers and will add additional

administrative costs to plans in legislation that seeks to increase dental MLRs. Delta Dental writes that dental plan loss ratios are not a useful or meaningful measure of a dental plan's value to consumers. Dental carriers face the same regulatory requirements and operational challenges as health plans despite having just 3% to 12% of the cost of health plans. It is counterproductive that this bill would on the one hand punish dental plans for spending too high a percentage of premiums on administration, and on the other hand, impose new requirements that would increase administrative costs without solving any problems in the marketplace. Delta Dental states that existing summary of benefit forms sent by dental carriers to all enrollees already describe dental policies in great detail. Additionally, with every covered dental service, patients and their dentists receive a detailed explanation of benefits detailing how the services was adjudicated, what the patient owes, what the plan paid and why the claim was adjudicated as it was. Carrier websites and call centers provide additional detail regarding how coverage was applied, and all providers, in network or out, share an equal degree of access to this information.

Aetna writes that this bill lacks any real problem to solve. Dental premiums in California are among the lowest in the nation. United Concordia Dental writes that in order to achieve the loss ratios proposed by this bill, dental plans would have to enhance benefit designs or increase reimbursement to dentists. Dental HMO benefits provide significant value for Californians. The average premium is $13.04 and average administrative expense is 10% to 30%, this leaves $1.30 to $3.90 to pay claims, administer enrollment changes, collect premium, manage appeals, maintain websites and provider directories, maintain a distribution panel of producers, and recruit, credential and retain dentists. Anthem writes that the uniform benefit disclosure forms increase administrative costs with no meaningful benefit to consumers. Instead, Anthem suggests requiring the posting of charges per American Dental Association procedure code in each dental office; have dental practices place a listing of all dental networks and insurance accepted by the dental practice in a prominent place in 14 point font; and, require dentists to post consumer complaint procedures.

The Consumer Health Alliance has two major concerns. First, the definitions of discount dental product and dental discount plan create confusion and an indirect approach to exempting discount programs from the DLR requirements. Second, there is only one type of discount product – a non-insurance program that provides access to discounted services. DMHC possesses ongoing authority to change or modify any current disclosure requirements for any of their licensed entities as such the bill's disclosure requirements duplicate existing law and is unnecessary. The National Association of Dental Plans (NADP) writes that most consumers will see no benefit from premium increases when coverage of current benefits is increased or when new covered procedures are added, resulting in as many as two million dropping coverage. Decreases in dental coverage will result in lower use of dental services and increases in medical costs as well as use of emergency rooms for dental treatment. More Californians will move to self-insured dental coverage outside the reach of statute and regulation and market consolidation will result. NADP also states that the dental discount plan and product definitions are not needed and none of the uniform benefit disclosure form would apply to a discount product, so the form for a discount dental product would be filled in with "not applicable" except for indicating that the product provides for discounts. These new definitions are the first introduction of specific discount terminology into the Health and Safety Code and bear closer scrutiny for their impact.

11) *Policy comments*. Purchasing dental services can be confusing. Dental is considered an "excepted benefit" which means many of the ACA requirements, such as guaranteed issue,

no annual and lifetime limits, out-of-pocket maximums, MLR, and other ACA requirements do not apply, with some exceptions associated with pediatric dental benefits that are mandated as one of the ten essential health benefits permitted to be sold by health plans and insurers and standalone dental plans. There are also discount cards for dental services that are sold by licensed health plans and insurers, and other entities not licensed by CDI or DMHC. Consumers seeking to purchase dental services, particular as individual purchasers, should have a clear understanding of the cost and benefits of a product being considered and the extent to which there is benefit over paying a dentist directly for services.

12) *Amendments*.

a. The author requests the Committee approve amendments to delete Sections 2 and 5 of this bill related to MLR requirements. If the MLR provisions were to remain, amendments to those sections would be needed to reflect that there are not grandfathered plans; that risk adjustment, reinsurance, and risk corridors are not applicable; and to exempt Medi-Cal dental plans.

b. Should the MLR provisions be deleted additional amendments should also be considered, such as:

   i. *Section 1 and 8, delete (a)(6) When the disclosure form is updated, the applicable medical loss ratio for the prior year.*
   ii. *Delete Section 9. It is the intent of the Legislature to enact legislation by 2024 to incrementally increase the minimum medical loss ratios applicable to specialized health care service plans and specialized health insurance policies that cover dental services, as established by the amendments to Section 1367.003 of the Health and Safety Code and Section 10112.25 of the Insurance Code made by this act, until these ratios are equal to the minimum medical loss ratios that are applicable to other health care service plans and health insurers.*

c. The Committee may wish to request that sections 1, 4, 6 and 8 be amended to establish a reasonable date by which plans would be required to comply with these provisions, in particular for the provisions that require the development of forms. Sections 1 and 8 also cannot be implemented until after emergency regulations are promulgated.

SUPPORT AND OPPOSITION:

Support: California Dental Association
Health Access California
Western Center on Law and Poverty

Oppose: Aetna
American Council of Life Insurers
Ameritas Life Insurance Corp.
Anthem
California Association of Dental Plans
California Association of Health Plans
California Association of Health Underwriters

California Dental Network
Consumer Health Alliance
Delta Dental of California
Dental Health Services
Guardian Life Insurance Company of America
Liberty Dental
Metropolitan Life Insurance Company
National Association of Dental Plans
Principle Financial Group
San Francisco Chamber of Commerce
Sun Life Financial
United Concordia Companies, Inc

-- END --