Abbreviated Analysis

California Assembly Bill 2028: Medical Loss Ratios (Dental)

Report to the 2023–2024
California State Legislature

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CHBRP

California Health Benefits Review Program
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Summary

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an abbreviated analysis of California Assembly Bill (AB) 2028. AB 2028 would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a (dental) medical loss ratio (MLR) of 85% and to provide a specified rebate to an enrollee or insured if the minimum MLR is not met. The bill, as written, would require dental MLRs to be calculated each year. The bill's 85% dental MLR would apply to both the Department of Managed Health Care (DMHC)- and California Department of Insurance (CDI)-regulated dental plans and policies, in the individual, small-group, and large-group markets.[2] The bill excludes the Medi-Cal program.

Background

Oral health care services are generally provided by a loosely organized network of private practices and the oral health care safety net.

The majority of people in California are enrolled in dental benefit plans that are "fully insured[3]" and regulated at the state level by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). Coverage for major restorative services can be limited in many dental plan designs and products (even if plans do not have pre-existing condition exclusions or waiting periods). Dental plans in California are generally either dental health maintenance organizations (DHMOs) or dental preferred provider organizations (DPPOs).

A dental MLR is similar to a medical loss ratio (MLR) for health insurance plans – it is the percentage of premium that a carrier spends on clinical costs and health improvement measures (versus administration costs, profit, etc.). A dental MLR is generally calculated by dividing the amount of dental insurance premiums spent on clinical costs and health improvement measures by the total amount of dental insurance premiums collected.

Dental MLR in California

The blended current DHMO[4] MLR across the individual, small-group, and large-group markets is 58.5%. The blended current DPPO[5] MLR across the individual, small-group, and large-group markets is 76.8%. None of the current DHMO or DPPO market segments, in the aggregate, are currently in compliance with the proposed dental MLR requirement of 85%; however, the DPPO large-group segment comes closest at 83%.

Dental MLRs vary by case size segment and by product type. DHMO loss ratios are generally lower than DPPO, and individual/small-group loss ratios are lower than large-group loss ratios.

Under the Affordable Care Act (ACA), Congress established the MLR for health plans to provide "greater transparency and accountability around the expenditures made by health insurers and to help bring down the cost of health care" (Kirchhoff and Mulvey, 2014). The MLRs required of health plans are feasible in part because the ACA standardized benefit design by requiring 10 essential health benefits. Dental insurance premiums are less expensive than medical insurance premiums, averaging 1/20th of the amount. This makes the administrative costs more difficult to be absorbed within the premiums.[6] The ACA did not impose MLR requirements on dental insurance plans.

[1] Refer to CHBRP's full report for full citations and references.
[2] The bill only applies to state-regulated plans and policies (not dental plans that fall under federal regulation [ERISA Plans or Taft-Hartley Plans]).
[3] A fully-insured health plan refers to a group health plan in which the employer or association purchases health insurance from a commercial insurer in order to provide coverage for its employees or association members.
[4] A DHMO provides lower cost coverage with a focus on preventive care. DHMO plans are designed to encourage regular dental visits and check-ups while minimizing spending. Enrollees are required to select a primary dental facility to manage and coordinate oral health needs, and the networks are generally considerably more limited than PPO Plans.
[5] PPO dental plans generally entail higher out-of-pocket costs than DHMO plans – but they also offer enrollees more flexibility when choosing a dentist or dental facility. A PPO dental plan will typically have a larger network of dental providers.
[6] Although dental insurance is less comprehensive and therefore medical necessity or utilization review or quality initiatives are less complex and limited than dental, they do require overhead.

Although dental insurance plan premium costs are low in comparison to health insurance, the costs of administering dental insurance have similarities to medical insurance.

Policy Context

In 2014, California passed AB 1962 requiring dental insurance plans to file annual MLR reports. The Legislature stopped short of requiring plans to achieve specific MLRs, deciding instead to assess reported MLRs and revisit the threshold requirement in 2018. In 2018, SB 1008 proposed a minimum MLR of 70% for dental plans in the individual and small-group markets, and 75% in the large-group market, but amendments removed these thresholds in May 2018. Only the annual MLR reporting is currently in effect.

Starting in 2024, Massachusetts will collect current and projected financial information from dental insurance plans and assess whether the dental loss ratio is being met or whether the insurer would be required to distribute a rebate. However, the 83% minimum dental MLR requirements are not yet in place to draw insights into the potential impacts of AB 2028.

Other states have made efforts to introduce dental MLRs. However, Massachusetts is distinct as being the only state thus far to enact a percentage minimum with required remediation (rebates) if not achieved. A few other states have introduced legislation similar to AB 2028, with lower MLR requirements, but these have not been enacted.

Relevant Populations

AB 2028 would require a dental MLR of 85% to be applied to state-regulated plans and policies, excluding dental plans that fall under federal regulation (ERISA[7] Plans or Taft-Hartley Plans) and dental plans in the Medi-Cal program.

Using 2022 data, dental insurers reported enrollment of 2,082,137 Californians enrolled in state-regulated dental HMO products and 7,651,281 Californians enrolled in dental PPO products.

Potential Implications

Based on present market reports and dynamics, most of the illustrative implications in this report represent potentially significant levels of disruption and premium increases to market participants, particularly in the individual and small-group dental HMO and PPO insurance markets. It is possible that over the long term, acceptance of higher-priced dental insurance products could increase and dental plan product design may evolve. CHBRP used the calendar year 2021 and 2022 composite market dental MLRs to model the potential impacts of minimum dental MLR thresholds on California dental insurers. Each dental plan would be affected differently by a minimum loss ratio threshold, as stipulated by AB 2028. No single insurer would experience the results shown in the modeled scenario, rather the illustrative projections are made across market segments.

Premium Impacts

The ability to meet a particular minimum dental MLR threshold will vary by product and size segment. Smaller insurers tend to have more difficulty meeting any particular minimum loss ratio threshold, although variations exist.

CHBRP projects that after plans first reduce profits and improve administrative efficiency to the extent feasible, DHMO plans would need to raise premiums by 215% in the individual market, 266% in the small-group, and 145% in the large-group market to comply with AB 2028.

CHBRP projects that DPPO plans (which have higher enrollment) would need to raise premiums by 78% in the individual market, 114% in the small-group, and 13% in the large-group market to comply with AB 2028.

California is unique in its higher prevalence of DHMOs than other states. Based on the market data, a single uniform minimum dental MLR across product lines would, on average, have a greater impact on DHMO products than DPPO products.

Dental insurance is known to be an important factor in a person's decision to seek and use dental care services. Previous studies have shown that people with dental coverage at all income levels are more likely to report having had a dental visit than those without dental coverage.

Potential Results

For the market segments likely to experience significant premium increases under AB 2028, it is unknown whether employers and employees (and individual policyholders) will value the higher-priced products enough to continue purchasing them. Insurers could discontinue dental plans with leaner benefit options (and

[7] The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

lower premiums) if the administrative expenses cannot be funded.

If the minimum dental MLR constrains the feasibility of a particular segment for an insurer, the insurers could withdraw from that market segment or sell that block of business.

CHBRP viewed it as likely that as a first step, insurers could respond to minimum dental MLR regulation by making reductions in commissions and fees to agents and brokers. While this reduces cost (and would have the effect of increasing an insurer's calculated dental MLR), it could also trigger a decline in sales if broker/agent compensation were reduced. Brokers and agents provide services to consumers (as well as small-group and some large-group plan sponsors/employers) in the form of expert advice, facilitating enrollment, and customer service, and their removal from the market could be disruptive for small-group plan sponsors and individual consumers purchasing plans and policies.

AB 2028 may result in a movement away from fully insured dental products toward self-funded arrangements. The self-insured arrangements do not fall under state regulation and are governed under ERISA. Some individuals may no longer purchase the higher-priced policies, and some groups may discontinue offering dental or pass the costs on to enrollees; as a result, some people may face significantly higher out-of-pocket costs with delayed dental preventive care. This may result in poorer population-level oral health.

Potential Long-Term Implications

Based on present market reports and dynamics, most of the illustrative implications in this report represent potentially significant levels of disruption and premium increases to market participants, particularly in the Individual and Small Group Dental HMO and PPO Insurance Markets. It is possible that over the long term, acceptance of higher-priced dental insurance products could increase and dental plan product design may evolve.

Dental MLRs may result in an increased understanding of dental insurance premiums and finance mechanisms, providing consumers greater transparency of the dental insurance market and improving access to high-quality dental services. Individual and small group markets may not be willing to absorb more expensive products with richer benefits. Alternatively, while most insurers would not be able to meet the proposed 85% dental MLR standard unless they made significant changes to the way their business is conducted, CHBRP notes that there is currently a wide range of dental MLRs, and a few do meet the 85% standard (depending on market segment). Perhaps if lower MLR standards were set (by market segment) and staggered over multiple years, it is more likely that more plans would reach it.

Potential Oral Health Implications

Dental insurance is known to be an important factor in a person's decision to seek and use dental care services. Existing product enrollments and studies suggest that price sensitivity is higher for dental insurance than for health insurance. Studies have shown that people with dental coverage at all income levels are more likely to report having had a dental visit than those without dental coverage. Thus, more of the population may forego dental insurance and defer or delay dental care. This in turn may negatively impact oral health.

Background

Beyond tooth health, oral health encompasses systemic issues including chronic oral-facial pain, mouth and throat cancers, soft tissue lesions, and congenital defects of cleft lip and palate. Oral health also encompasses the connective tissues, ligaments, and bones in or interfacing with the mouth and teeth, as well as the nervous, immune, and vascular systems that affect the mouth (DHHS, 2021). Various oral conditions such as infections, immune disorders, injuries, and cancers can affect functioning in other parts of the human body. Likewise, systemic conditions such as diabetes, high blood pressure, respiratory problems, and stroke can impact oral health (Tavares et al., 2014). A "silent epidemic" of dental and oral diseases disproportionally affects some populations of Americans, particularly children, the elderly, and racial/ethnic minorities (DHHS, 2021).

Dental care is a relatively modern phenomenon, with oral health care historically limited to rudimentary tooth repair or extraction (Ring et al., 2018). As dentistry became an established profession, dental care shifted from tooth extractions and alleviating pain to hygiene and prevention of disease (Ring et al., 2018). Fluoridation of municipal water supplies in the United States became more widespread, with most communities adding supplemental fluoride by the 1940s and 1950s. The vast majority of dentists in the United States work in private practice settings, whereas smaller numbers of dentists work in hospitals, public health clinics, military settings, or government facilities such as prisons (Ring et al., 2018).

In 1954, labor unions sought to add dental coverage as a "fringe benefit" and consulted with state dental societies in Washington, Oregon, and California to develop a benefit where care would be delivered in the dentist's office, creating prepaid plans (Bishop, 1983). The separation of oral health care from the broader health care system began with the compartmentalization of dental and medical education, which led to distinct delivery, coding, and payment systems (Mertz, 2016).

Access to comprehensive oral health care continues to be one of the biggest challenges within the oral health care system and a key driver of oral health care inequity. Many Americans regularly seek care for nontraumatic dental conditions in hospital emergency departments that are not equipped to provide comprehensive or definitive oral health care (Allareddy et al., 2014). Patients seeking care in the emergency department may be uninsured, qualify for Medicaid (Fellows et al., 2022), or are unable to find a dental office that accommodates their work schedule (Fellows et al., 2022). Others simply cannot afford the deductibles and copayments of private dental insurance programs (although much lower than medical insurance and deductibles generally do not apply to preventive or diagnostic services). Dental insurance is known to be an important factor in a person's decision to seek and use dental care services. Previous studies have shown that people with dental coverage at all income levels are more likely to report having had a dental visit than those without dental coverage.

Oral health care services are generally provided and financed through a two-tier system in the United States. Approximately two-thirds of the American population utilize commercial dental insurance or out-of-pocket spending while the remaining one-third use Medicaid and various government or discounted safety-net clinics (Northridge et al., 2020). Financing is either provided by a third party (i.e., private/Medicaid) or is self-pay. Community health centers, commonly referred to as Federally Qualified Health Centers, provide dental care on a sliding scale for the uninsured.[8] Dental spending represented approximately 4% of total health care spending in California in 2020 (CHCF, 2023).[9] This is a

[8] Safety net clinics, including dental schools and federally qualified health centers (FQHCs), serve as care delivery sites for millions of adults and children who are uninsured or enrolled in public insurance. From 2001 through 2020, the number of people (nationally_ obtaining oral health care at FQHCs increased from 1.4 million to 5.2 million.

[9] 2020 may have been atypical given utilization delays of dental services during the pandemic.

reduction from the past (6% in 2010 and 5% in 2015) as dental spending growth was significantly slower than the growth of other components of health care spending (CHCF, 2023). California's dental spending is similar to national averages.

Dental Insurance Landscape in California

Dental insurance commonly divides oral health services into categories. The most common service categories include preventive and diagnostic, basic restorative services, major restorative services, and orthodontics. Preventive and diagnostic services are typically the most generous in terms of coverage. Basic restorative services include treatments for common dental problems and are generally straightforward and nonsurgical in nature, such as simple extractions and basic root canals (endodontic). Major restorative services, however, are often complex or lengthy, typically requiring more time and expense than basic services. Coverage for major restorative services can be limited in many dental plan designs and products (even if plans do not have pre-existing condition exclusions or waiting periods).

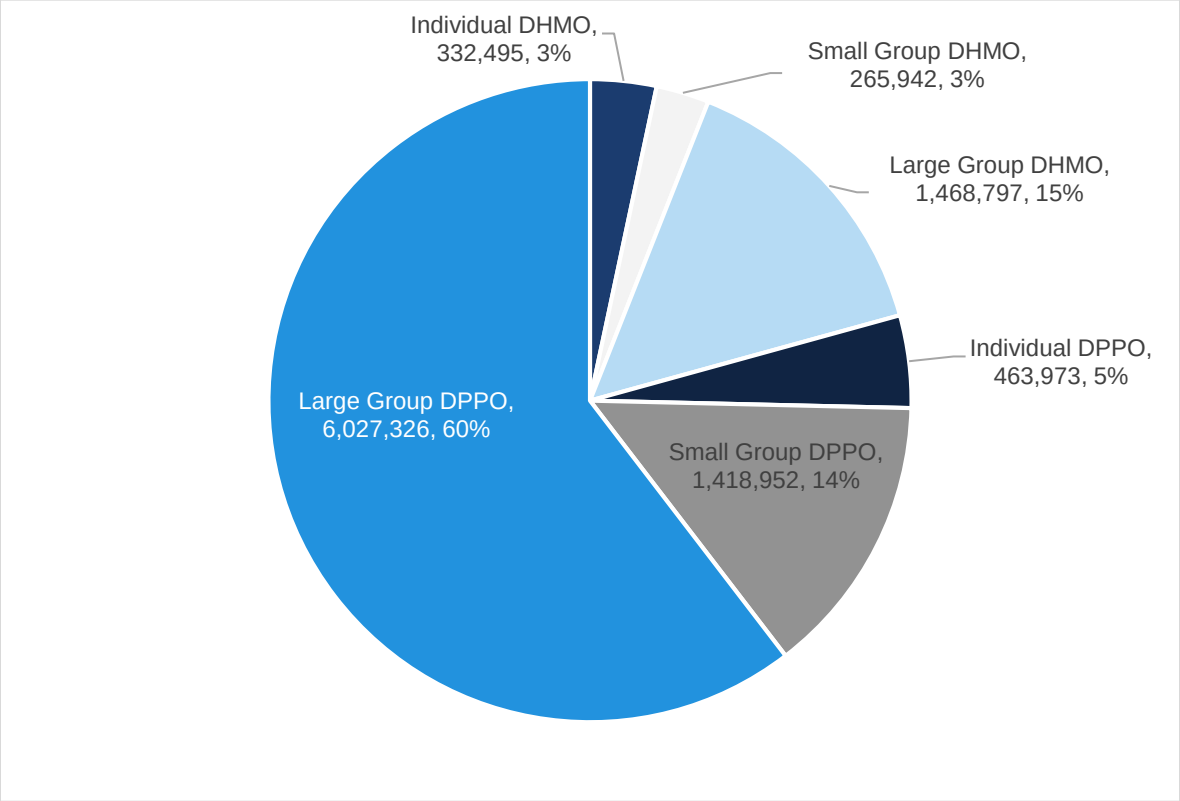
Unlike medical insurance, dental insurance commonly includes an annual benefit maximum, or cap, thus limiting many enrollees to a fixed amount of covered dental services (Northridge et al., 2020; Versaci, 2022). These caps, which typically range from $1,500 to $2,500 annually, often apply to both commercial or private dental insurance and government-sponsored or public insurance. As a result of these caps, significant out-of-pocket spending may be required for more expensive dental services even when these services are covered by the dental insurance plan. Although preventive dental care may require more subsequent oral health care services, the provision of preventive dental care is associated with reduced total dental expenditures (Pourat et al., 2018).

According to the CDA, the majority of Californians enrolled in dental benefit plans are in "fully insured" plans or policies, which are regulated at the state level by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).[10] Akin to health insurance, fully insured state-regulated dental plans must comply with all California's rules and regulations. In addition, many employers and plan sponsors offer "self-insured" plans, for roughly 40% of Californians. These plans are regulated at the federal level according to the Employee Retirement Income Security Act of 1974, known as ERISA, and are exempt from state rules and regulations. Self-insured employer plans are more likely to be those covering unions, municipalities, school districts, multi-state employers, and large employer groups. A self-funded dental plan is a benefit plan provided to employees and their eligible dependents by an employer or plan sponsor and pays for all eligible services rendered.[11] A self-funded employer may administer their plan in-house or hire a third-party administrator (TPA) to administer their plan. A TPA may provide many administrative services including but not limited to claims processing, actuarial services, and other administrative services.

Fee-for-service financing was the first mode of payment for oral health services and remained the main type of payment for many years until the other forms of payment came into existence (Burt and Eklund, 1992). The mid-to-late 1940s saw the launch of the first prepaid or broader-based insurance plans. Eventually preferred provider organization (PPO) dental insurance was introduced in the 1960s. A dental health maintenance organization (DHMO) provides lower-cost coverage with a focus on preventive care. DHMO plans, introduced in the 1980s, are designed to encourage regular dental visits and check-ups while minimizing spending. Enrollees are required to select a primary dental provider to manage and coordinate oral health needs, and the networks are generally considerably more limited than PPO Plans. PPO dental plans generally entail higher premiums and out-of-pocket costs than DHMO plans – but they also offer enrollees more flexibility when choosing a dental provider. A PPO dental plan (DPPO) will typically have a larger network of dental providers. Figure 1 shows 2022 enrollment by product and line of business.

[10] https://www.cda.org/newsroom/2023/cda-sponsored-bill-signed-into-law-improves-dental-plan-disclosures-for-dentists-patients/.
[11] Stop loss insurance is very commonly used in connection with self-insured arrangements.

Figure 1. 2022 State-Regulated Dental Plan Enrollment, by Line of Business and Product Type



Source: California Health Benefits Review Program, 2024.
Key: DHMO = dental health maintenance organization; DPPO = dental preferred provider plan.

In the California dental insurance market, there is a correlation between insurer size (measured by revenue) and the mix of business sold by the insurer (individual, small group, or large group). Table 1 (below) illustrates the correlation, classifying California dental insurers by total revenue for 2022. Insurers with greater than $20 million in revenue were classified as “Big”, insurers with less than $3 million in revenue were classified as “Small”, and the remainder of dental insurers were classified as “Medium.” This baseline table illustrates some of the unique dynamics that may result in rapid consolidation were AB 2028 to pass, which is discussed in the Impacts Section.

Table 1. 2022 State-Regulated Dental Plan Revenue Source, by Insurer Size

Insurer Size	Average Proportion of 2022 Dental Revenue From Large-Group Size Segment
Big (23 insurers)	64%
Medium (20 insurers)	35%
Small (22 insurers)	21%

Source: California Health Benefits Review Program, 2024.

Covered California

In Covered California plans, adult California residents may select a health plan with or without dental benefits. If enrollees select a health plan without dental benefits, they can still get a separate dental plan. All Covered California health

insurance plans include embedded pediatric dental coverage (the dental benefits and premiums are embedded in the health plan premiums). There is a small portion of dental-only plans sold through the ACA health insurance marketplace each year. Dental plans offered on the marketplace are governed by a set of standardized rules. For example, ACA-compliant dental coverage must have an actuary certify its "actuarial value." Actuarial value refers to the portion of covered services paid by the dental carrier relative to the patient's copayments and deductibles. Additionally, pediatric dental plans have an out-of-pocket maximum like health insurance.

Covered California 2024 dental HMO plan monthly premiums range from $7.50 to $15.00 per person. Covered California PPO Dental Plan monthly premiums are between $44.00 to $60.00 per person. PPO dental plans in Covered California cover some services such as cleanings, x-rays, and exams at $0 cost to the enrollee. For minor and major restorative services, there is usually a deductible of $50 and enrollee coinsurance. The annual adult maximum benefit for the PPO plans is $1,500.[12] There is also a 6-month waiting period before the PPO dental plan will share in the cost of any minor or major restorative services for adults.

Loss Ratios

Medical Loss Ratios and the Affordable Care Act

Conceptually, a loss ratio represents the proportion of premiums directed toward patient care; i.e., how much of each premium dollar is used to pay health providers for services to plan enrollees. The "traditional" loss ratio calculation is simply the ratio of claims cost to premium; this general insurance concept is used broadly across all types of insurance.

While some form of MLR regulation has existed at the state level since 1980 (Cicala, 2017), it was typically used as a tool to assess and compare insurer value. The MLRs required of health plans are feasible in large part because the ACA standardized benefit design by requiring 10 essential health benefits.

Under the ACA, Congress established the MLR to provide "greater transparency and accountability around the expenditures made by health insurers and to help bring down the cost of health care" (Kirchhoff and Mulvey, 2014). The ACA introduced a modified MLR concept for health plans, allowing taxes and fees to be subtracted from the premium used in the denominator, and allowing quality improvement expenses to be added to the numerator. The rationale for subtracting taxes and fees is to not penalize insurers for passing through governmental, mandated expenses, which may also differ by state or other jurisdiction. The rationale for including quality improvement expenses is to avoid discouraging investments in improving health outcomes just because those expenses are not part of claims expense.

The ACA MLR reporting uses a 3-year experience period, to enhance the credibility and stability of the calculation and smooth year-to-year fluctuations. Acknowledging differences in volatility by block size, the calculation also explicitly incorporates credibility adjustments based on the number of life-years insured, allowing smaller blocks of business an additive adjustment to their calculated MLR. After an initial phase-in period, the ACA established minimum MLRs of 80% for individual and small-group medical plans and 85% for large-group medical plans. Health insurers are required to pay rebates to policyholders within a line of business whenever the MLR is less than the minimum threshold. Other types of coverage, such as those with a lower premium basis and those without the obvious quality improvement activities for which managed medical plans can receive MLR credit, require different loss ratio constructs.

The ACA exempted some special lines of health insurance business from MLR requirements. These exemptions included some specific circumstances such as coverage for citizens living abroad and mini-med plans;[13] they were deemed as having unique cost structures warranting a customized or transitional MLR formula. Dental plans were also specifically exempted from the ACA's MLR rules and requirements.

[12] After any applicable deductible, the PPO plans will cover 80% of minor restorative procedures (fillings) and 50% of major work such as crowns and extractions.
[13] Mini-med health plans feature very limited benefits. These plans are offered by certain employers, unions and purchased by individuals who buy on their own.

Policy Context

The California Assembly Committee on Health requested on February 13, 2024, that the California Health Benefits Review Program (CHBRP) conduct an abbreviated analysis of California Assembly Bill (AB) 2028. AB 2028 would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a (dental) medical loss ratio (MLR) of 85% and to provide a specified rebate to an enrollee or insured. The bill, as written, would calculate the dental MLR each year. The bill's 85% dental MLR would apply to both DMHC- and CDI-regulated dental HMO and PPO plans and policies, in the individual, small-group, and large-group markets.[14] The bill excludes the Medi-Cal program.[15]

California Policy Landscape

California law and regulations

In 2013, the California Legislature considered requiring health insurers that offered pediatric dental coverage through the Covered California Marketplace to maintain a medical loss ratio of 75%.[16] In 2014, California passed AB 1962 requiring dental insurance plans to file annual MLR reports (Finocchio and Connolly, 2018). These reports are publicly available on the DMHC and CDI websites for all California dental insurers operating in the state. The Legislature stopped short of requiring plans to achieve specific MLRs, deciding instead to assess reported MLRs and revisit the threshold requirement in 2018. In 2018, SB 1008 proposed a minimum MLR of 70% for dental plans in the individual and small-group markets, and 75% in the large-group market, but amendments removed these thresholds in May 2018. No MLR standards were set, but annual reporting continued.

In 2023, AB 1048 (2023)[17] (Wicks) was passed and enacted. Effective as of January 2025, the bill prohibits plans from denying claims related to a patient's pre-existing dental conditions and prohibits plans in the large-group market from imposing waiting periods before patients can access their full benefits. AB 1048 also requires state regulatory review of the premiums charged by dental plans to help protect consumers from unreasonable or unjustified rates.

Another bill related to dental insurance was also signed into law in 2023. AB 952 requires dental plans to disclose at the time of coverage determination whether a patient's plan is state or federally regulated under the federal Employee Retirement Income Security Act (ERISA).

California Oral Health Plan 2018-2028

California's Oral Health Plan 2018-2028 was developed in response to the California State Legislature's request that the California Department of Public Health prepare an assessment of the burden of oral diseases in California and lead the development of an oral health plan based on the findings of that assessment. The assessment identified insufficient infrastructure to promote culturally sensitive community-based oral health programs; insufficient data to inform interventions; a range of barriers preventing access to preventive and treatment services; a lack of implementation of evidence-based and demonstrable models of oral disease prevention and dental treatment; and a lack of consistent and effective messaging to encourage improvements in oral health, among other issues (Kumar and Jackson, 2018).

[14] The bill only applies to state-regulated plans and policies (not dental plans that fall under federal regulation [ERISA Plans or Taft-Hartley Plans]).
[15] (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148). See Appendix A for the version of AB 2028 analyzed by CHBRP (the introduced version).
[16] AB 18 (Pan) introduced on December 3, 2012. The bill died in the Appropriations Committee.
[17] AB 1048, as introduced, was analyzed by CHBRP. Analysis is available at: https://www.chbrp.org/analysis/completed-analyses.

Many of the recommended action steps focus on prevention and increasing access, with particular emphasis on children. Other action steps include continue monitoring caries (cavities) and untreated caries in children and expand to include monitoring by race/ethnicity, county of residence, and social determinants of oral health such as dental insurance.

Other States

Massachusetts offers the closest parallel to AB 2028, however, the implementation of the law is not yet fully in effect. In 2022, the Massachusetts electorate approved a ballot measure[18] requiring the state to leverage the MLR mechanism by legislating compulsory MLR financial reporting rules for dental insurers and establishing an 83% loss ratio. The ballot measure also required dental insurers to issue rebate payments to enrollees should loss ratio requirements not be met and the measure permits the insurance commissioner to disallow premium rate increases above a particular threshold. Massachusetts is establishing a structure to limit formula increases that set premium amounts, requiring insurers to issue rebates if they exceed the 83% loss ratio, incorporating wide-ranging financial and operational reporting requirements, and making MLR determinations and data publicly available. Implementation begins in 2024. Due to the MLR changes, a few dental carriers have announced plans to pull out of the small-group market in Massachusetts (Bailey, 2023).

In 2023, Arizona, Colorado, and Nevada adopted limited dental (medical) loss ratio legislation. CHBRP is aware of nine states that have introduced legislation establishing dental MLR thresholds in 2024: Illinois, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island, Virginia, Washington, and West Virginia. States have approached this issue in a variety of ways. Proposed (introduced, but not enacted) legislation in Rhode Island, for instance, would require insurers to report a wide range of financial data, including their dental loss ratios. It would set limits on what can be considered an expense for dental care versus overhead costs and require refunds to covered patients when dental insurers spend less than 85% of premium revenue on dental care expenses. A bill in Oklahoma that failed in 2023 would have set the minimum loss ratio at 80% with a similar refund requirement for plans spending less than 80% and calls for an insurer rate review process in which premium increases are prohibited. All of the introduced dental MLR bills include components of insurer reporting requirements.

Additionally, the National Council of Insurance Legislators (NCOIL) voted in January 2024 to pass model legislation[19] for a dental loss ratio. The model legislation includes language negotiated between the American Dental Association and the National Association of Dental Plans, which represents dental insurance and third-party payer companies.

[18] Language available at: **https://ballotpedia.org/Massachusetts_Question_2,_Medical_Loss_Ratios_for_Dental_Insurance_Plans_Initiative_(2022)**.
[19] Available at https://ncoil.org/wp-content/uploads/2024/01/NCOIL-DLR-Model-Health-Cmte-Adopted-1-26-24.pdf.

Potential Short-Term Impacts

AB 2028 would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a (dental) medical loss ratio (MLR) of 85% and to provide a specified rebate to an enrollee or insured. The bill, as written, would calculate the dental MLR each year. The bill's 85% dental MLR would apply to both DMHC- and CDI-regulated dental HMO and PPO plans and policies, in the individual, small-group, and large-group markets.[20] The bill excludes the Medi-Cal program.[21]

Because there is not yet evidence from Massachusetts regarding the potential impact of a dental MLR minimum threshold requirement, it is not possible to accurately predict the market response. Multiple potential outcomes may occur in response to AB 2028. Although listed as discrete outcomes, it is possible for many of the dynamics described to occur. In considering the impacts, CHBRP offers the following potential implications:

- Most dental insurers will respond by increasing the premiums. This assumes that some aspects of the administrative costs are fixed and so raising premiums, effectively, lowers the ratio of fixed administrative costs to premiums. This would continue until the insurer could meet the 85% ratio. This scenario would likely increase premiums to the point where some in the market would cease coverage. The percentage loss of those with coverage would depend on the price elasticity of demand for dental insurance, but it is likely to be significant. This scenario is modeled in the illustrative example that follows.
- The administration of dental MLR results in cost-cutting and efficiencies on the part of the insurers to the point where their profits and administrative costs are lowered until they meet the 85% dental MLR. Those insurers who were not able to make the 85% ratio would likely cease offering coverage. This might be taken up by other, more efficient insurers, or there might be less coverage overall in the marketplace. Regardless, this might have an impact on the quality of service offered to consumers by all insurers as they would be under significant pressure to reduce their administrative support and other services.
- Insurers could discontinue leaner benefit options with lower premiums if the administrative expenses cannot be funded. These leaner, lower premium options may be appealing to price-driven consumers who would potentially be left with fewer (if any) affordable options. Many in the market may cease coverage.
- If the minimum dental MLR constrains the feasibility of a particular segment for an insurer, the insurers could withdraw from that market segment or sell that block of business.
- There could be a consolidation of the market if some insurers cannot shift to a cost structure that complies with a new minimum dental MLR.
- Insurers may respond to minimum dental MLR regulation by making reductions in commissions and fees to agents and brokers. While this reduces cost (and would have the effect of increasing an insurer's calculated dental MLR), it could also trigger a decline in sales if broker/agent compensation were reduced. Brokers and agents provide services to consumers (and small groups) in the form of expert advice, facilitating enrollment, and customer service, and their removal from the market could be impactful to small-group plan sponsors and individual consumers purchasing plans and policies.
- AB 2028 may result in a movement away from fully insured dental products toward self-funded arrangements that do not rely on a loss ratio construct. The self-insured arrangements do not fall under state regulation and are governed under ERISA.

[20] The bill only applies to state-regulated plans and policies (not dental plans that fall under federal regulation (ERISA Plans or Taft-Hartley Plans).
[21] (Chapter 7, commencing with Section 14000, and Chapter 8, commencing with Section 14200 of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2, commencing with Section 15810, of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4, commencing with Section 15870, of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148). See Appendix A for the version of AB 2028 analyzed by CHBRP (the introduced version).

Illustrative Example

In the scenario modeled below, CHBRP assumes that dental insurers' response to minimum dental MLR requirements would not simply adjust premiums downward and allow financial losses to occur; they would also attempt to adjust various components of their cost structure to comply. CHBRP used aggregate 2021-2022 as a baseline and then made assumptions/adjustments to illustrate the impacts of the 85% dental MLR required by AB 2028.

CHBRP used the calendar year 2021 and 2022 composite market dental MLRs to model the potential impact of minimum dental MLR thresholds on California dental insurers. CHBRP assumed that the composite DHMO industry experience is representative of an illustrative DHMO insurer, and similarly, CHBRP assumed the composite DPPO experience to be representative of an illustrative DPPO insurer. It is important to note that each dental plan would be affected differently by a minimum loss ratio threshold and that no single insurer would experience the results shown in the modeled scenarios. CHBRP did not apply trend to 2025.

Tables 2 and 3 show the dental MLRs by product and market segment at baseline. The premiums consist of claims and administration costs. The administration costs include taxes and fees, profit, and all other nonclaim costs. Nonclaim costs include fees associated with administering the plan such as salaries, broker fees and commissions, fines and penalties, and other administration fees. The dental MLR is calculated as the claims divided by the premium less taxes and fees.

Table 2. Baseline 2021-2022 Financial Results for DHMO Insurers in California by Market Segment

		Individual	Small Group	Large Group	Aggregate
Average annual enrollees	A	325,085	246,994	1,510,059	2,082,137
Claims	B	$6.04	$5.86	$8.79	$8.01
Administration costs					
Taxes and fees	C	$0.22	$0.52	$0.75	$0.64
Nonclaim costs	D	$3.46	$5.22	$3.87	$3.97
Profit	E	$0.52	$2.03	$1.93	$1.72
Profit (% premium)	*E / F*	*5%*	*15%*	*13%*	*12%*
Premium	F = B + C + D + E	$10.24	$13.63	$15.34	$14.34
Dental MLR	**B / (F - C)**	**60.3%**	**44.7%**	**60.2%**	**58.5%**

Source: California Health Benefits Review Program, 2024.

The aggregate premium of the DHMO market is $14.34 with average line of business premiums ranging from $10.24 in the individual market to $15.34 in the large-group market. The aggregate dental MLR is 58.5% with aggregate dental MLRs by line of business ranging from 44.7% in the small-group market to 60.3% in the individual market.

Table 3. Baseline 2021-2022 Financial Results for DPPO Insurers in California by Market Segment

		Individual	Small Group	Large Group	Aggregate
Average annual enrollees	A	441,899	1,352,888	5,856,493	7,651,281
Claims	B	$25.32	$29.39	$33.03	$31.94
Administration costs					
Taxes and fees	C	$2.15	$1.73	$0.93	$1.14
Nonclaim costs	D	$8.39	$11.35	$4.92	$6.26
Profit	E	$9.86	$7.91	$1.85	$3.38
Profit (% premium)	*E / F*	*22%*	*16%*	*5%*	*8%*
Premium	F = B + C + D + E	$45.72	$50.38	$40.73	$42.72
Dental MLR	**B / (F - C)**	**58.1%**	**60.4%**	**83.0%**	**76.8%**

Source: California Health Benefits Review Program, 2024.

The aggregate monthly premium of the DPPO market is $42.72 with the average line of business premiums ranging from $40.73 in the large-group market to $50.38 in the small-group market. The aggregate dental MLR is 76.8% with aggregate dental MLRs by line of business ranging from 58.1% in the individual market to 83.0% in the large-group market.

In 2021-2022, profit percentages in DPPO products are 22% in the individual markets and 16% in the small-group markets. The unusually high-profit margin may be an aberration that is related to the deferred utilization of dental services during the COVID-19 pandemic (Kranz et al., 2021; Moynihan et al., 2021).[22]

As mentioned above, postmandate, CHBRP assumes that dental insurers' response to minimum dental MLR requirements would not simply be to adjust premiums downward and allow financial losses to occur; they would also attempt to adjust various components of their cost structure to comply. CHBRP assumed that dental insurers would make some changes in their approach and attempt to meet the 85% dental MLR requirement. Specifically, CHBRP assumed that insurers would first reduce profit levels to 5% of premiums. If the result of this action does not meet the 85% dental MLR requirement (which CHBRP projects would generally not be sufficient for most dental plans), then CHBRP assumed the insurer would attempt to, and successfully, reduce administrative expenses by 10%. Finally, if the result of these actions did not satisfy an 85% dental MLR requirement, then CHBRP assumed the dental plan would increase claim costs through enhancing benefits and/or increasing dental provider compensation. See the *Methodology and Assumption* section in Appendix B for more information on these adjustments and key assumptions.

For both DHMO and DPPO products and all lines of business, the profit cap of 5% and administrative expense reduction of 10% were not enough to meet the 85% dental MLR threshold. Claims increases were required. Tables 4 and 5 show the claims increase required by product and line of business. DHMO plans have lower premiums than DPPO plans and administration costs account for a greater proportion of DHMO premiums. This results in DHMO plans needing to raise claims more than DPPO plans to meet the proposed 85% dental MLR threshold.

Table 4. 2021-2022 Claims Increase Required to Meet 85% Dental MLR for DHMO Insurers in California by Market Segment

	Individual	Small Group	Large Group	Aggregate
Baseline claims	$6.04	$5.86	$8.79	$8.01
Postmandate claims	$26.78	$40.74	$30.38	$31.05
Claims change	**$20.75**	**$34.88**	**$21.59**	**$23.04**
Claims change, %	**344%**	**595%**	**246%**	**288%**

Source: California Health Benefits Review Program, 2024.

Table 4 shows that the claims increase required for DMHO plans in the aggregate to meet the Dental MLR requirement, after reducing profit and administrative costs, is $23.04, or 288%. The small group market requires the largest claims increase of $34.88 or 595%.

Table 5. 2021-2022 Claims Increase Required to Meet 85% Dental MLR for DPPO Insurers in California by Market Segment

	Individual	Small Group	Large Group	Aggregate
Baseline claims	$25.32	$29.39	$33.03	$31.94
Postmandate claims	$65.77	$88.38	$38.10	$48.59
Claims change	**$40.45**	**$58.99**	**$5.07**	**$16.64**
Claims change, %	**160%**	**201%**	**15%**	**52%**

Source: California Health Benefits Review Program, 2024.

[22] The ongoing COVID-19 pandemic has had a tremendous impact on the health care systems of affected countries. With regard to the impact on the utilization of health care services, a systematic review found that the overall health care utilization across 20 countries had declined by one-third during the pandemic. Utilization of dental care was similarly impacted; a U.S. study found a 33% reduction in weekly visits to dental clinics from January to August 2020, compared with the same time frame in 2019.

Table 5 shows that the claims increase required for DPPO plans in the aggregate to meet the dental MLR requirement, after reducing profit and administrative costs, is $16.64, or 52%. The large-group market requires the lowest claims increase of $5.07, or 15%. The small-group market requires the largest claims increase of $58.99, or 201%.

Tables 6 and 7 show the premium increase corresponding to the profit and administrative cost reductions and claims increase required to meet the 85% dental MLR.

Table 6. 2021-2022 Premium Increase Required to Meet 85% Dental MLR for DHMO Insurers in California by Market Segment

	Individual	Small Group	Large Group	Aggregate
Baseline premium	$10.24	$13.63	$15.34	$14.34
Postmandate premium	$32.22	$49.83	$37.59	$38.20
Premium change	**$21.98**	**$36.19**	**$22.25**	**$23.86**
Premium change, %	**215%**	**266%**	**145%**	**166%**

Source: California Health Benefits Review Program, 2024.

Table 6 shows that the premium increase required for DHMO plans in the aggregate to meet the 85% dental MLR requirement is $23.86, or 166%, from $14.34 at baseline to $38.20 postmandate. The aggregate small-group premiums increase the most of all DHMO plans with a $36.19, or 266%, premium increase.

Table 7. 2021-2022 Premium Increase Required to Meet 85% Dental MLR for DPPO Insurers in California by Market Segment

	Individual	Small Group	Large Group	Aggregate
Baseline premium	$45.72	$50.38	$40.73	$42.72
Postmandate premium	$81.19	$107.69	$45.86	$58.83
Premium change	**$35.48**	**$57.31**	**$5.14**	**$16.11**
Premium change, %	**78%**	**114%**	**13%**	**38%**

Source: California Health Benefits Review Program, 2024.

Table 7 shows that the premium increase required for DPPO plans in aggregate to meet the 85% dental MLR requirement is $16.11, or 38%. The large-group market requires the lowest claims increase of $5.14, or 13%. The small-group market requires the largest claims increase of $57.31, or 114%.

Enrollment Impact

The resulting elevated premium levels may result in dental product offerings that are not marketable to individuals or to employer groups. This may present significant disruptions to the state-regulated dental insurance markets. As previously mentioned, CHBRP expects that many enrollees may cease to have coverage as a result of such premium increases. The percentage loss of those with coverage would depend on the price elasticity of demand for dental insurance, but it is likely to be significant.

Dental benefits in the private market are primarily voluntary and therefore subject to offer and take-up. Voluntary benefits are services and/or goods that an employer offers at a discounted group rate but are paid for (either fully or partially) by an employee through a payroll deduction. Voluntary benefits are supplemental to other traditional benefits (health insurance, retirement, etc.). But while prices and information are undeniably key factors for understanding individual decisions around health insurance coverage, they alone are insufficient to explain certain observed patterns. A third factor, the psychology of individual decision-making, plays a central role in driving coverage outcomes (Baicker et al. 2012). Findings from behavioral economics and psychology indicate that individuals may have difficulty implementing the

optimal choices that would be in their private interest (even if they did not differ from broader social goals). This may add a new dimension to the policy challenges associated with dental coverage and determining the impacts of AB 2028 on enrollment. Moreover, and crucially, behavioral factors might interact with traditional economic forces such as prices and information to complicate both their implementation and the ultimate effects. For example, decision-making errors that are correlated with oral health status might affect the extent of adverse selection[23] and therefore affect the level and distribution of dental insurance coverage.

Due to the complexity of the interaction between adverse selection and elasticity of demand, CHBRP did not model the enrollment loss as a result of the 85% dental MLR required by AB 2028.

For more detailed exhibits displaying the baseline and Postmandate dental MLR calculations, please visit Appendix C.

Considerations

Poorer Population-Level Oral Health and Increased Medical Costs

If price-sensitive individual and small group enrollees end up without dental coverage, they may face significantly higher out-of-pocket costs and/or delayed dental preventive care. This may result in poorer population-level oral health, potentially resulting in higher overall health care costs. Tooth decay, gum infections, and tooth loss can be prevented in part with regular visits to the dentist (Kumar and Jackson, 2018). Dental insurance is known to be an important factor in a person's decision to seek and use dental care services. Previous studies have shown that people with dental coverage at all income levels are more likely to report having had a dental visit than those without dental coverage (Manski and Cooper, 2010).

Dental MLRs by Product Type

As noted above, DHMOs are much more common in California than nationwide. According to the National Association of Dental Plans 2021 State of the Dental Market report, 2020 enrollment in DHMO plans represented 4% of all commercial dental benefits, with the vast majority (86%) of the commercial market enrolled in DPPO products. (NADP, 2021) In California, based on the reported enrollment for the 2021 dental MLR 3-year reporting period, 23% of enrollment is in DHMO plans. Other states such as Maine (in its proposed earlier proposed 2021 legislation)[24] and Massachusetts did not consider product differentials in their Dental MLR requirements as DHMOs are uncommon in those markets.

Rebate Feasibility

Some minimum loss ratio rules use rebates as an enforcement mechanism, requiring insurers with loss ratios below the minimum to rebate the difference to policyholders as a premium refund or credit. The ACA established de minimis thresholds of $20 applied to group medical plans and $5 for individual medical plans, below which rebates were not required to be produced.[25] Under those same thresholds, the expected annual rebate payable to dental plan enrollees may often fall below the minimum. If a rebate provision is contemplated as part of minimum dental MLR regulation, consideration should be given to the relative premium levels for dental insurance compared to medical and at what point annual dental MLR rebates will be below de minimis amounts. The bill as it is written is silent on setting de minimis

[23] According to actuary.org, adverse selection is when an insurance market or insurer attracts a disproportionate number of unhealthy people. This occurs because people with more health care needs are more likely to purchase health insurance and with better benefits than those with fewer health care needs.
[24] Progress on Maine LD 1266, which would have established a minimum dental loss ratio of 80% for all dental plans and require rebates, stalled in the Health Coverage Insurance and Financial Services Committee (HCIFS), a joint committee of the Maine House and Senate.
[25] 45 CFR § 158.243

amounts. The administrative processing associated with issuing rebates may also warrant consideration, as the additional administrative costs could outweigh the dollar value of the rebates. These administrative costs could lead to either financial losses to insurers, or higher premiums (with corresponding higher claims) to maintain the mandated MLR.

Loss Ratio Definition

If a minimum loss ratio is being considered, it is important to understand how the particulars of the loss ratio formula being contemplated will affect the ability of insurers to achieve that minimum. This report analyzes the effects of the California AB 1962 Dental MLR calculation methodology, as applied to composite California dental insurer results. For a different loss ratio calculation methodology, the results would differ accordingly. For example, AB 1962 allows for particular taxes and government fees to be excluded from the denominator of the loss ratio, acknowledging that some expenses are unrelated to operational efficiency and not within the insurer's control. More broadly, the impact of the allowable exclusions from the denominator, and allowable additions to the numerator, of the calculation is an important consideration to be factored into the selection of an appropriate minimum loss ratio threshold.

Postmandate Potential Long-Term Impacts

Based on present market reports and dynamics, most of the illustrative implications in this report represent potentially significant levels of disruption and challenge to market participants, particularly in the individual and small-group dental HMO and PPO insurance markets. It is possible that over the long term after shorter-term disruption and premium increases, acceptance of higher-priced dental insurance products could increase across market segments. In addition, AB 2028 may drive some less efficient dental plans from the market.

Dental MLRs may result in an increased understanding of dental insurance premiums and finance mechanisms, providing consumers greater transparency of the dental insurance market and improving access to high-quality dental services. Perhaps in this scenario, dental insurer disruption is modest. Individual and small-group markets absorb more expensive products with richer benefits. A limited number of plans do seem to operate within the 85% dental MLR in some cases.

Over the next few years, Massachusetts will offer other states insight into how legislation similar to AB 2028 may impact dental insurance markets and individuals and purchasers. Considerable uncertainties as to how the markets and its participants would respond to AB 2028 make firm predictions nearly impossible.

In the short term, CHBRP's estimates suggest that the scale of significant premium increases necessary to meet the 85% MLR required in AB 2028 appears to largely be a mathematical construct to achieve the required ratios. Spending on dental care (payments to providers) must go up in orders of magnitude in the numerator, either through increased utilization of dental services or higher per-service fees. The individual and small-group segments would be impacted more than large group markets, and the impacts in the DHMO plans would be highest. In tandem, the total premium dollars (in the denominator) would also rise to allow for a ratio that accommodates the administrative costs of operating dental plans, and that covers the increased dental benefit costs to meet the 85% ratio. While the relative dollars in dental insurance premiums are more modest than health insurance, the percentage increases may be seen by market participants as insurmountable.

Similarly, the response from dental insurers is unknown. It is possible that some smaller and medium-sized insurers, in particular, will withdraw from the market. Part of the value proposition for purchasers of dental insurance has been access to the discounts available to dental provider networks, operated by dental plans. Whether consumers and small-group purchasers would be willing and able to pay higher premiums is unknown (although the fact that few such plans exist in the market points to at least the low perceived demand), and whether the most efficient dental plans would stay in the market and win outsized market shares is unknown.

As noted in the Short-Term Impacts section, CHBRP believes that there is significant potential for considerable disruption to dental insurers, providers, consumers, and small groups. Uncertainties in marketplaces tend to create more uncertainties in underwriting (Kunreuther et al., 1993), which may further drive up dental insurance premium costs, impacting premiums and enrollment in dental plans over the longer term. Higher costs tend to impact the utilization of oral health services. Delays in care (especially routine treatments and prevention) may further increase the costs of oral health treatments, further increasing future insurance premiums. Dental insurance is known to be an important factor in a person's decision to seek and use dental care services. Previous studies have shown that people with dental coverage at all income levels are more likely to report having had a dental visit than are those without dental coverage (Manksi et al., 2002).

Appendix A. Text of Bill Analyzed

On February 13, 2024, the California Assembly Committee on Health requested that CHBRP analyze AB 2028 as introduced on February 1, 2024.

ASSEMBLY BILL **NO. 2028**

Introduced by Assembly Member Ortega
(Coauthor: Senator Durazo)

February 01, 2024

An act to amend Section 1367.004 of the Health and Safety Code, and to amend Section 10112.26 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2028, as introduced, Ortega. Medical loss ratios.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. The federal Patient Protection and Affordable Care Act requires a health insurance issuer to comply with minimum medical loss ratios (MLRs) and to provide an annual rebate to each insured if the MLR of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified. Existing law requires health care service plans and health insurers that issue, sell, renew, or offer a contract or policy, excluding specialized dental and vision contracts and policies, to comply with a minimum MLR of 85% and provide specified rebates. Existing law requires a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services to annually report MLR information to the appropriate department.

This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.004 of the Health and Safety Code is amended to read:

1367.004.(a) A health care service plan that issues, sells, renews, or offers a contract covering dental services shall file a report with the department by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and shall contain the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health care service plan's MLR annual report on its ~~Internet Web site~~ *internet website* within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If the director decides to conduct a financial examination, as described in Section 1382, because the director finds it necessary to verify the health care service plan's representations in the MLR annual report, the department shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

(d) The health care service plan shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 1381. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) (1) A health care service plan that issues, sells, renews, or offers a contract covering dental services shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the plan on the costs for reimbursement for dental services provided to enrollees under that coverage and for activities that improve dental 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 85 percent.

(2) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the amount by which the percentage described in paragraph (1) exceeds the plan's MLR reported pursuant to subdivision (a) multiplied by 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.

~~(f)~~

(g) This section does not apply to a health care service plan contract issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

~~(g)~~

(h) The department may issue guidance to specialized health care service plans subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Insurance in issuing the guidance specified in this section.

SEC. 2. Section 10112.26 of the Insurance Code is amended to read:

10112.26.(a) A health insurer that issues, sells, renews, or offers a policy covering dental services shall file a report with the department, by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health insurer's MLR annual report on its ~~Internet Web site~~ *internet website* within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations.

(c) If the commissioner decides to conduct an examination, as described in Section 730, because the commissioner finds it necessary to verify the health insurer's representations in the MLR annual report, the department shall provide the health insurer with a notification 30 days before the commencement of the examination.

(d) The health insurer shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 733. The commissioner may extend the time for a health insurer to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) (1) A health insurer that issues, sells, renews, or offers a policy covering dental services shall provide an annual rebate to each insured under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the insurer on the costs for reimbursement for dental services provided to insureds under that coverage and for activities that improve dental 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 85 percent.

(2) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the amount by which the percentage described in paragraph (1) exceeds the insurer's MLR reported pursuant to subdivision (a) multiplied by 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.

~~(f)~~

(g) This section does not apply to an 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) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

~~(g)~~

(h) This section does not apply to disability insurance for covered benefits in the single specialized area of dental-only health care that pays benefits on a fixed benefit, cash payment only basis.

~~(h)~~

(i) The department may issue guidance to health insurers of specialized health insurance policies subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this section.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Appendix B. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

Analysis-Specific Data Sources

We downloaded all California insurer dental MLR reporting data from the publicly available Department of Managed Health Care and California Department of Insurance web portals. The data for the calendar year 2021 and 2022 financial reports were used to create composite dental MLRs for individual, small-group, and large-group segments separately by DHMO and DPPO.

Analysis-Specific Caveats and Assumptions

Methodology and Assumptions

Dental Medical Loss Ratio (MLR) Calculation

The dental MLR is calculated as the claim costs divided by the adjusted premium. The adjusted premium is calculated as premium minus excludable taxes and fees. The taxes and fees that are excluded from the denominator are:

- Federal income tax and other federal taxes,
- State income, excise, business, and other taxes,
- State premium tax,
- Community benefit expenditures (primarily made by tax-exempt insurers in lieu of state premium taxes), and
- Regulatory authority licenses and fees.

Assumptions for Illustrative Insurer Reaction

- CHBRP used the calendar year 2021 and 2022 composite market dental MLRs to model the potential impact of minimum dental MLR thresholds on California dental insurers. CHBRP assumed that the composite DHMO industry experience is representative of an illustrative DHMO insurer, and similarly CHBRP assumed the composite DPPO experience to be representative of an illustrative DPPO insurer. It is important to note that each dental plan would be affected differently by a minimum loss ratio threshold, and that no single insurer would experience the results shown in the modeled scenarios.
- The further the current dental MLR is from the minimum dental MLR requirement dictates the magnitude of changes the insurer must make. Dental insurers must make changes to their cost structure to comply. Generally, insurers could adjust one or more of the following to meet the required cost to premium relativity: profit, administrative expenses, claim costs, or commissions.
- Each insurer would respond in a unique way to minimum loss ratio requirements based on their own circumstances including profitability, ability to reduce administrative expenses, commission levels, and other factors. The modeled scenario is meant to be broadly representative and reasonable rather than an indicator of how every insurer would react.
- CHBRP assumed that in order to meet the minimum dental MLR proposed in AB 2028 insurers would attempt the following three main cost structure changes:
    - Target profit levels of 5%,

- Reduce administrative costs by 10%, and
- Increase claims costs, via richer benefits and/or increased provider compensation, until the dental MLR requirement is met.

- CHBRP assumed that commissions, taxes, fees, and community benefit expenditures would remain constant as a percent of premium as the dental MLR changes.

Appendix C. Detailed Loss Ratio Exhibits

The following exhibits show the traditional loss ratio which is calculated as claims divided by premium. The Dental MLR with a target of 85% is calculated as the claims divided by premium less expenses excludable from the MLR denominator.

Table A. Baseline 2021-2022 Financial Results for DHMO Insurers in California by Market Segment

2021-2022 California Loss Ratio (LR) Calculation - PMPM Basis				
	DHMO			
	Individual	Small Group	Large Group	Aggregate
Traditional LR Calculation				
Average Annual Enrollees	325,085	246,994	1,510,059	2,082,137
Premium	$10.24	$13.63	$15.34	$14.34
Claims	$6.04	$5.86	$8.79	$8.01
Traditional LR	59.0%	43.0%	57.3%	55.9%
Expenses Excludable from Dental MLR Denominator				
Federal Income Tax	$0.02	$0.26	$0.40	$0.33
Other Federal Tax	$0.00	$0.01	$0.00	$0.00
State Income / Business / Other Tax	$0.02	$0.08	$0.14	$0.11
State Premium Tax	$0.00	$0.00	$0.00	$0.00
Community Benefit Expenditures	$0.08	$0.07	$0.10	$0.09
Regulatory Licenses and Fees	$0.10	$0.10	$0.10	$0.10
Total Expenses Excludable from Dental MLR	$0.22	$0.52	$0.75	$0.64
Total Expenses Excludable from Dental MLR (%)	2.2%	3.8%	4.9%	4.5%
Other Non-Claim Costs				
Direct Sales Salaries / Benefits	$0.47	$0.74	$0.62	$0.61
Agent / Broker Fees / Commissions	$0.31	$1.06	$0.52	$0.55
Other Taxes and Assessments	$0.00	-$0.02	$0.01	$0.01
Fines and Penalties	$0.00	$0.00	$0.00	$0.00
Other General Admin	$2.68	$3.44	$2.72	$2.80
Total Non-Claim Costs	$3.46	$5.22	$3.87	$3.97
Total Non-Claim Costs (%)	33.8%	38.3%	25.2%	27.7%
Profit and Dental MLR				
Profit	$0.52	$2.03	$1.93	$1.72
Profit (%)	5.0%	14.9%	12.6%	12.0%
Dental MLR	**60.3%**	**44.7%**	**60.2%**	**58.5%**

Source: California Health Benefits Review Program, 2024.

Table B. Baseline 2021-2022 Financial Results for DPPO Insurers in California by Market Segment

2021-2022 California Loss Ratio (LR) Calculation - PMPM Basis				
	DPPO			
	Individual	Small Group	Large Group	Total
Traditional LR Calculation				
Average Annual Enrollees	441,899	1,352,888	5,856,493	7,651,281
Premium	$45.72	$50.38	$40.73	$42.72
Claims	$25.32	$29.39	$33.03	$31.94
Traditional LR	55.4%	58.3%	81.1%	74.8%
Expenses Excludable from Dental MLR Denominator				
Federal Income Tax	$1.22	$0.64	$0.17	$0.31
Other Federal Tax	$0.04	$0.06	$0.03	$0.03
State Income / Business / Other Tax	$0.03	$0.05	$0.01	$0.02
State Premium Tax	$0.58	$0.84	$0.40	$0.49
Community Benefit Expenditures	$0.23	$0.11	$0.28	$0.24
Regulatory Licenses and Fees	$0.04	$0.03	$0.04	$0.04
Total Expenses Excludable from Dental MLR	$2.15	$1.73	$0.93	$1.14
Total Expenses Excludable from Dental MLR (%)	4.7%	3.4%	2.3%	2.7%
Other Non-Claim Costs				
Direct Sales Salaries / Benefits	$0.61	$0.75	$0.52	$0.57
Agent / Broker Fees / Commissions	$2.24	$5.25	$1.52	$2.22
Other Taxes and Assessments	$0.06	$0.05	$0.04	$0.04
Fines and Penalties	$0.00	$0.00	$0.00	$0.00
Other General Admin	$5.47	$5.30	$2.84	$3.43
Total Non-Claim Costs	$8.39	$11.35	$4.92	$6.26
Total Non-Claim Costs (%)	18.3%	22.5%	12.1%	14.6%
Profit and Dental MLR				
Profit	$9.86	$7.91	$1.85	$3.38
Profit (%)	21.6%	15.7%	4.5%	7.9%
Dental MLR	**58.1%**	**60.4%**	**83.0%**	**76.8%**

Source: California Health Benefits Review Program, 2024.

Table C. Postmandate Estimated Financial Impact of 85% Dental MLR Requirement for DHMO Insurers in California by Market Segment

California Loss Ratio (LR) Calculation - PMPM Basis 85% Dental MLR Requirement	DHMO			
	Individual	Small Group	Large Group	Aggregate
Traditional LR Calculation				
Average Annual Enrollees	325,085	246,994	1,510,059	2,082,137
Premium	$32.22	$49.83	$37.59	$38.20
Claims	$26.78	$40.74	$30.38	$31.05
Traditional LR	83.1%	81.8%	80.8%	81.3%
Expenses Excludable from Dental MLR Denominator				
Federal Income Tax	$0.06	$0.96	$0.99	$0.84
Other Federal Tax	$0.01	$0.03	$0.00	$0.01
State Income / Business / Other Tax	$0.05	$0.29	$0.34	$0.29
State Premium Tax	$0.00	$0.00	$0.00	$0.00
Community Benefit Expenditures	$0.26	$0.24	$0.25	$0.25
Regulatory Licenses and Fees	$0.33	$0.38	$0.26	$0.28
Total Expenses Excludable from Dental MLR	$0.71	$1.89	$1.84	$1.67
Total Expenses Excludable from Dental MLR (%)	2.2%	3.8%	4.9%	4.4%
Other Non-Claim Costs				
Total Non-Claim Costs	$3.12	$4.70	$3.48	$3.57
Total Non-Claim Costs (%)	9.7%	9.4%	9.3%	9.3%
Profit and Adjustment Summary				
Revised Profit	$1.61	$2.49	$1.88	$1.91
Revised Profit (%)	5.0%	5.0%	5.0%	5.0%
Premium Change	**215%**	**266%**	**145%**	**166%**
Claims Change	**344%**	**595%**	**246%**	**288%**

Source: California Health Benefits Review Program, 2024.

Table D. Postmandate Estimated Financial Impact of 85% Dental MLR Requirement for DPPO Insurers in California by Individual/Small Group/Large Group

California Loss Ratio (LR) Calculation - PMPM Basis 85% Dental MLR Requirement				
	DPPO			
	Individual	Small Group	Large Group	Aggregate
Traditional LR Calculation				
Average Annual Enrollees	441,899	1,352,888	5,856,493	7,651,281
Premium	$81.19	$107.69	$45.86	$58.83
Claims	$65.77	$88.38	$38.10	$48.59
Traditional LR	81.0%	82.1%	83.1%	82.6%
Expenses Excludable from Dental MLR Denominator				
Federal Income Tax	$2.17	$1.37	$0.19	$0.51
Other Federal Tax	$0.06	$0.14	$0.03	$0.05
State Income / Business / Other Tax	$0.05	$0.11	$0.02	$0.03
State Premium Tax	$1.04	$1.80	$0.45	$0.73
Community Benefit Expenditures	$0.42	$0.24	$0.31	$0.30
Regulatory Licenses and Fees	$0.07	$0.06	$0.05	$0.05
Total Expenses Excludable from Dental MLR	$3.81	$3.70	$1.04	$1.67
Total Expenses Excludable from Dental MLR (%)	4.7%	3.4%	2.3%	2.8%
Total Non-Claim Costs	$7.55	$10.21	$4.43	$5.63
Total Non Claim Costs (%)	9.3%	9.5%	9.7%	9.6%
Profit and Adjustment Summary				
Revised Profit	$4.06	$5.38	$2.29	$2.94
Revised Profit (%)	5.0%	5.0%	5.0%	5.0%
Premium Change	**78%**	**114%**	**13%**	**38%**
Claims Change	**160%**	**201%**	**15%**	**52%**

Source: California Health Benefits Review Program, 2024.

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, some other ongoing researchers and analysts are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, and authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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