# State of California
# Department of Managed Health Care (DMHC)
# and
# Department of Insurance (CDI)
# Medical Loss Ratio (MLR)
# Annual Reporting Form Filing Instructions

***Pursuant to Health and Safety Code section 1367.004 and Insurance Code section 10112.26***

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## Filing Instructions for the MLR Reporting Year

These are the filing instructions for the report to the DMHC and CDI as required by Health and Safety Code section 1367.004 and Insurance Code section 10112.26, respectively (AB 1962 (Skinner, 2014)), which includes elements that make up the medical loss ratio (MLR). The data included in the MLR Annual Reporting Form (MLR Form) are the exact data that will be used to calculate a health plan's MLR.

The Federal MLR implementing regulations can be found at: https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html

The DMHC MLR guidance and MLR reporting form can be found at: http://www.dmhc.ca.gov/LicensingReporting/SubmitFinancialReports.aspx

The CDI MLR guidance and MLR reporting form can be found at: http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm.

The guidance and forms for both departments are substantively identical.

**DMHC Filing Instructions**

All Dental Health Plans are required to submit an Electronic Signature Verification Form (Agreement). Once DMHC accepts this Agreement and the user ID, then a password to the DMHC web portal is sent to the plan. If a health plan is currently registered for DMHC's financial web portal, it does not need to register again. If there are any changes to the information in the Agreement, a new Agreement must be submitted to the DMHC. The Electronic Filing Signature Verification Form can be downloaded from the DMHC's website at:

https://www.dmhc.ca.gov/LicensingReporting/FilingandReportingProcess.aspx

Please send the Agreement to:

Department of Managed Health Care
ATTN: Licensing Administration
980 9th Street, Suite 500
Sacramento, CA 95814

All health plans are required to submit the MLR Annual report through the secured DMHC's financial web portal to the DMHC. The DMHC's financial web portal can be accessed at: https://wpso.dmhc.ca.gov/secure/login/. All financial information submitted via the financial web portal will be posted to the DMHC's public web site.

**CDI Filing Instructions**

Please submit the Medical Loss Ratio Reporting Form through SERFF. In the "filing description" field, please include the following: "Dental Medical Loss Ratio Report (AB 1962)".

**General Filing Instructions**

These Filing Instructions are to be used in completing the MLR Form by all health plans and health insurers offering specialized dental health care service plan contracts or specialized health insurance policies subject to Health and Safety Code section 1367.004 and Insurance Code section 10112.26, respectively (AB 1962 (Skinner, 2014)).

The requirements in this part apply to a health care service plan that issues, sells, renews, or offers specialized dental health care service plan contracts or specialized health insurance policies, to groups or individuals for dental health coverage. The term "dental coverage" means benefits consisting of dental care (provided directly through insurance or reimbursement, or otherwise and including items and services paid for as dental care) under a dental service plan contract or specialized health insurance policy. This definition applies to any stand-alone dental products which are not subject to federal MLR reporting requirements. These requirements do not include uninsured or self-funded business, Medicare (Title XVII), Medicaid (Title XXI), State Children's Health Insurance Program (SCHIP) (Title XI), other Federal and State government-sponsored coverage (other than the Federal Employees Health Benefits Program or State government sponsored coverage for State employees or retirees) including Healthy Kids Program and as specifically excluded in Health and Safety Code section 1367.004(f).

An MLR Form must be prepared and submitted for each California specialized health care service plan or health insurance policy that has written direct dental service coverage or has direct amounts paid, incurred, or unpaid for the provision of oral health care services. The MLR Form must aggregate data for each entity licensed in California, aggregated separately by product type for the large group market, the small group market and the individual market.

## General Reporting Instructions

**Deferred Business:**
If, for any aggregation as defined in §5, 50% or more of the total earned premium for an MLR reporting year is attributable to newly issued policies with less than 12 months of experience in that MLR reporting year, then the experience of these policies may be deferred, at the option of the health plan or health insurer. If a health plan or health insurer defers the reporting of newer business as provided in this paragraph, then the experience of such policies must be excluded from the MLR reporting year in which it occurred and must be added to the experience reported in the following MLR reporting year.

**Transfer of Block of Business:**
Health plans or health insurers that purchase a block of business from another health plan or health insurer during an MLR reporting year are responsible for submitting the information and reports required by this part for the assumed business, including for part of the MLR reporting year that was prior to the purchase. All earned premium for policies issued by one health plan or health insurer and later assumed by another health plan or health insurer for the entire MLR reporting year during which the policies were assumed and no earned premium for that MLR reporting year must be reported by the ceding health plan or health insurer.

**Allocation of Expenses:**
Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between the two (or more) types of expenses. Expenditures that benefit more than one affiliate may be allocated, on a pro rata basis, between the affiliates that benefit from these expenditures. Expenditures that benefit all lines of business or products, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata basis.

**Aggregation of Experience:**
A health plan's or health insurer's experience, aggregated by individual, small group, and large group markets, with respect to each policy must be included on the report submitted with respect to California where the policy was issued, except as specified below.

**Individual Business through an Association:**
For individual business sold through an association which provides dental service coverage to California enrollees, the health plan or health insurer shall include the experience in the MLR Form.

**Employer Business through Group Trust, Association, or MEWA:**
For employer business issued through a group trust which provides dental service coverage to California enrollees, the health plan or health insurer shall include the experience in the MLR Form. For employer business issued through a multiple employer welfare association (MEWA) which provides dental service coverage to California

enrollees, the health plan or health insurer shall include the experience in the MLR Reporting Form.

**Definition of Small Group and Large Group:**

The large group and small group markets are defined as those where dental service coverage is obtained by a large or small employer, respectively. Large employer and small employer are defined by the number of employees employed; small group is defined as "any person, firm, proprietary or nonprofit corporation, partnership public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but not more than 100, eligible employees." [Health and Safety Code section 1357(l)(1) and Insurance Code section 10753(q)(1)(A)].

A health plan or health insurer must report on this MLR Form only the business issued by the reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the enrollee ***must not*** be included in this MLR Form.

## Column Definitions for MLR Annual Reporting Form − Parts 1 and 2

Dental coverage, Columns 1 through 12, includes contracts/policies that provide dental service coverage, including direct claims paid to and/or received for services by dental providers (general/specialists), capitation basis contracts with dental providers, and payment of services for dental clinical services or supplies covered by contract.

Do not include in Columns 1–12 business specifically uninsured or self-funded business, Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP) (Title XXI), other Federal or State government-sponsored coverage (other than the Federal Employees Health Benefits Program or State government sponsored coverage for State employees or retirees), and Healthy Kids Program, as specifically excluded by Health and Safety Code section 1367.004(f) and Insurance Code section 10112.26(f).

For any data element that is not separately reported in the financial statement filings to the health plan's or health insurer's regulatory authority, a health plan or health insurer does not need to separately report that element in the 12/31 column of the MLR Form. However, a health plan or health insurer must separately report that data element in the 3/31 column as instructed in the guidance and MLR Form instructions. For example, a health plan or health insurer may not need to report the amount of contingent benefit and lawsuit reserves in Part 2, Line 2.10 in the 12/31 column, but must report such amounts in the 3/31 column. A health plan or health insurer must still report, in the detail provided by the MLR form, the amounts for premiums and unearned premium reserves, taxes and fees, claims and claims-related reserves, and non-claims costs, in both the 12/31 and the 3/31 columns, to the extent the health plan or health insurer reports such amounts to the health plan's or health insurer's regulatory authority.

Columns 1, 3, 5, 7, 9, 11 – **Business as of 12/31 of the MLR reporting year**

**For health care service plans**: Financial information reported for the 12/31 columns are to equal the exact amounts that were reported directly to the DMHC by the health plan, prior to filing the MLR Form.

Include: Experience of policies in each of the relevant markets for the MLR reporting year, as reported as of December 31, to the DMHC on the DMHC's reporting form filing for the MLR reporting year regardless of incurred date.

**For health insurance policies**: Include experience of policies in each of the relevant markets for the MLR reporting year, as of December 31.

Columns 2, 4, 6, 8, 10, 12 – **Business as of 3/31 of subsequent MLR reporting year**

Financial Information reported in the 3/31 columns should equal the amount of each element related specifically to experience in the MLR reporting year and paid through March 31 of the subsequent reporting year (incurred in 12, paid or received in 15), plus any provision for items properly allocable to the MLR reporting year but not yet paid as of 3/31 of the following year.

Include: Experience of policies in each market, incurred, paid or received relevant only to the MLR reporting year, reported as of March 31 of the subsequent MLR reporting year.

Columns 1–2 and 7-8 **Individual Market (DHMO and DPPO & Indemnity Products)**

Include: Dental service coverage where the policy is issued to an individual covering the individual and his or her dependents in the individual market.

Columns 1–2 DHMO Products

Columns 7–8 DPPO & Indemnity Products

Columns 3–4 and 9-10 **Small Group Market (DHMO and DPPO & Indemnity Products)**

Include: All policies issued in the small group market (including fully insured State and local government policies).

Columns 3–4 DHMO Products

Columns 9–10 DPPO & Indemnity Products

Columns 5–6 and 11-12 **Large Group Market (DHMO and DPPO & Indemnity Products)**

Include: All policies issued in the large group market (including the Federal Employees Health Benefit Program and fully insured State and local government policies).

Columns 5–6 DHMO Products

Columns 11–12 DPPO & Indemnity Products

## Instructions for MLR Annual Reporting Form – Cover Page

Line 1 – MLR Reporting Year

Enter MLR Reporting Year.

Line 2 – Health Plan ID

Enter DMHC's license health plan identification. Health insurers may leave this field blank.

Line 3 – Legal Name

Enter health plan or health Insurer legal name.

Line 4 – Doing Business As (DBA)

Enter health plan or health insurer dba, if any.

Line 5 – Federal Tax Exempt Status?

Please enter Yes or No.

## Instructions for MLR Annual Reporting Form − Part 1
## (Summary of Data)

These MLR Form Filing Instructions only apply to the MLR reporting year and its reporting requirements.

In addition to the instructions below, the General Reporting Instructions and Column Definitions at the beginning of these Filing Instructions apply to Part 1. The General Reporting Instructions and Column Definitions include instructions regarding reporting of, individual business through an association, and an employer business through a group trust or MEWA.

Please note that the MLR Form and Filing Instructions implement the requirements of Health and Safety Code section 1367.004 and Insurance Code section 10112.26 and are not identical to the definitions or instructions of the DMHC reporting form.

**Section 1 – Premium:**

Line 1.1 – Total direct premium earned.

Part 2, Lines 1.1 + 1.2 – 1.3 – 1.4.

**Section 2 – Claims:**

Line 2.1 – Total incurred claims.

Part 2, Line 2.11.

**Section 3 – Federal and State Taxes and Licensing or Regulatory Fees:**

Line 3.1 – Federal taxes and assessments incurred by the reporting health plan or health insurer during the MLR reporting year.

3.1a – Federal income taxes deductible from premiums in MLR calculations.

Include: Federal income taxes attributed to the MLR reporting year allocated to the respective lines of business reported.

Exclude: Federal income taxes on investment income and capital gains.

3.1b – Other Federal Taxes (other than income tax) and assessments deductible from premium.

Include: Federal taxes and assessments (other than income taxes) allocated to the respective lines of business.

Exclude: Fines, penalties, and fees for examinations by any Federal departments.

Line 3.2 – State insurance, premium, and other taxes incurred by the reporting health plan or health insurer during the MLR reporting year (deductible from premium in MLR calculation).

3.2a – State income, excise, business, and other taxes, allocated to the respective lines of business reported, that may be excluded from earned premium.

Include:

- Any industry wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State
- Guaranty fund assessments
- Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States
- State income, excise, and business taxes other than premium taxes

Exclude: Fines, penalties, and fees for examinations by any State departments.

3.2b – State premium taxes.

Include: State premium taxes or State taxes based on policy related to the respective lines of business.

3.2c – Community benefit expenditures deductible from premium in MLR calculations.

Federal tax exempt health plans or health insurers: May report a value for 3.2b *and* 3.2c. Community benefit expenditures are limited to the highest of either:

1. Three percent of earned premium; or
2. The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the health plan's or health insurer's earned premium in the applicable State market.

Non-Federal tax exempt health plans or health insurers: May report a value for 3.2b *or* 3.2c, but not both. Health plans or health insurers *may not* report zero ($0) community benefit expenditures in lieu of negative State premium taxes. Community benefit expenditures are limited to:

- The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the health plan's or health insurer's earned premium in the applicable State market.

If a health plan or health insurer uses the highest premium tax rate in the State, the health plan or health insurer must report the applicable highest State health

premium tax rate in Part 5, Line 1.

**Note:** Health plans or health insurers must indicate their Federal tax exempt status in the header of Cover Page.

**Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to oral health care services, enhancing public health, and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial or cultural barriers to accessing oral health care services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address Federal, State or local public health priorities, such as advancing oral health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 3.3 – Regulatory authority licenses and fees incurred by the reporting health plan or health insurer during the MLR reporting year.

Include: Statutory assessments to defray operating expenses of any State or Federal regulatory authority, and examination fees in lieu of premium taxes as specified by State law.

Exclude: Fines, penalties, and fees for examinations by any State or Federal regulatory authority other than as specifically included in Line 3.3.

Line 3.4 – Total Federal and State Taxes and fees to be excluded from premium.

12/31 Column
Federal tax-exempt health plans or health insurers:
Part 1, Lines 3.1a + 3.1b + 3.2a + 3.2b + 3.2c + 3.3.

Not Federal tax-exempt health plans or health insurers:
Part 1, Lines 3.1a + 3.1b + 3.2a + (the higher of 3.2b or 3.2c) + 3.3.

3/31 Column
Federal tax-exempt health plans or health insurers:
Part 1, Lines 3.1a + 3.1b + 3.2a + 3.2b + 3.2c + 3.3.

Not Federal tax-exempt health plans or health insurers:
Part 1, Lines 3.1a + 3.1b + 3.2a + (the higher of 3.2b or 3.2c) + 3.3.

Note: If Line 3.2b is negative and Line 3.2c is zero or blank (or vice versa), zero may not be used as the higher of the two: only the negative amount may be used in the equation.

**Section 4–Non-Claims Costs**

Line 4.1 – Direct sale salaries and benefits.

Include compensation (including but not limited to salary and benefits) to employees engaged in soliciting and generating sales to policyholders for the health plan or health insurer.

Line 4.2 – Agents and brokers fees and commissions.

All expenses incurred by the health plan or health insurer payable to a licensed agent, broker, or producer who is not an employee of the health plan or health insurer in relation to the sale and solicitation of policies for the health plan or health insurer.

Line 4.3 – Other taxes.

4.3a – Taxes and assessments not excluded from premium.

Include:

- Taxes and assessments not deducted from Premium in Section 3.

- State sales taxes if the health plan or health insurer does not exercise the option of including such taxes with the cost of goods sold and services purchased.

4.3b – Fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than those included in Line 3.3 above.

Line 4.4 – Other general and administrative expenses.
Include: Expenses for quality improvement type activities, if applicable.

- Cost containment expenses.

Include: Expenses that serve to actually reduce the number of health services provided or the cost of such services.

This category can include costs only if they result in reduced costs or services such as:

- Pre-service utilization review
- Detection and prevention of payment for fraudulent requests for reimbursement
- Expenses for internal and external appeals
- Network access fees to preferred provider organizations and other network-based health plans and allocated internal salaries and related costs associated with network development and/or provider contracting

- All other claims adjustment expenses

Include any expenses for administrative services that do not constitute adjustments to premium revenue, reimbursement for dental clinical services to enrollees or expenditures on quality improvement activities or cost containment expenses.

This category can include such costs as:

- Estimating the amount of losses and disbursing loss payments
- Maintaining records, general clerical and secretarial costs
- Office maintenance, occupancy costs, utilities, and computer maintenance
- Supervisory and executive duties
- Supplies and postage

Include: General and Administrative Expenses not previously reported in Sections 1, 2, or 3 above.

These expenses include such examples as:

- Salaries
- Outsource services
- EDP equipment, other equipment
- Reimbursement by uninsured plans and fiscal intermediaries
- Community benefit expenditures – report only the amount in excess of what is already reported in Part 1, Line 3.2c
- Other additional expenses not included in another category such as rent, legal fees and expenses, dental examination expenses, inspection reports, professional consulting fees, travel, advertising, postage, utilities, etc.

Exclude:

- Any elements already reported on Lines 4.1, 4.2, 4.3
- Rating agencies and other similar organizations

Line 4.5 – Total non-claims costs.

12/31 Column
Part 1, Lines 4.1 + 4.2 + 4.3 + 4.4.

3/31 Column
Part 1, Lines 4.1 + 4.2 + 4.3 + 4.4.

**Section 5 – Other indicators or information**

Line 5.1 – Number of covered lives.

This is the total number of lives insured, including dependents, under individual policies and under group certificates as of the last day of the reporting year. Reasonable approximations are allowed when exact information is not available to the health plan or health insurer.

Line 5.2 – Member months.

The total number of lives, including dependents, insured on a pre-specified day of each month of the reporting period. Reasonable approximations are allowed when exact information is not available to the health plan or health insurer.

Line 5.3 – Number of life-years.

Part 1, Line 5.2 / 12.

**Section 6 – Net investment income and other gain/ (loss)**

Enter the Grand Total as of 12/31 for ALL markets in Columns 1– 12.

**Section 7 – Other Federal income taxes**

Enter the Grand Total as of 12/31 for ALL markets in Columns 1–12.

Include: Federal income taxes on investment income and capital gains.

Exclude: Taxes entered on Part 1, Lines 3.1a and 3.1b.

## Instructions for MLR Annual Reporting Form − Part 2
## (Premium and Claims)

These MLR Form Filing Instructions only apply to the MLR reporting year and its reporting requirements.

In addition to the instructions below, the General Reporting Instructions and Column Definitions at the beginning of these Filing Instructions apply to Part 2. The General Reporting Instructions and Column Definitions include instructions regarding reporting of individual business through an association, employer business through a group trust or MEWA.

Please note that the MLR Form and Filing Instructions implement the requirements of Health and Safety Code section 1367.004 and Insurance Code section 10112.26 and are not identical to the definitions or instructions of the DMHC reporting form.

**Section 1 – Health Premiums Earned**
Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving dental coverage from the health plan or health insurer, including any fees or other contributions associated with the health plan or health insurer and reported on a direct basis.

Line 1.1 – Direct premium written.

12/31 Column – report amount as of 12/31 of the MLR reporting year, as reported to the regulatory authority in the health plan or health insurer for the MLR report year.

3/31 Column (premium for coverage in MLR reporting year only) – report premium collected from 1/01 of the MLR reporting year through 3/31 of the year following the MLR reporting year for coverage in the MLR reporting year only, plus uncollected (due and unpaid) premium for coverage in the MLR reporting year only as of 3/31 of the year following the MLR reporting year. Premium should reflect retroactive eligibility adjustments related to coverage in the MLR reporting year. However, health plan or health insurer may choose to report amounts on the same basis as in the 12/31 columns.

Line 1.2 – Unearned premium (year preceding the MLR reporting year).

12/31 Column – report reserves established to account for the portion of the premium paid prior to the MLR reporting year that was intended to provide dental service coverage during the MLR reporting year. Report reserves as of 12/31 of the year preceding the MLR reporting year, as reported to the regulatory authority of the health plan or health insurer for the year preceding the MLR reporting year.

3/31 Column (premium for dental service coverage in the MLR reporting year only) – report premium for dental service coverage in the MLR reporting year only, collected in the immediately preceding MLR reporting year. Report amounts as of 12/31 of the year preceding the MLR reporting year. However, if the health plan or health insurer chose to report direct written premium in Line 1.1 on the same

basis as in the 12/31 column, the health plan or health insurer should report unearned premium reserves consistently with how it reports direct written premium.

Line 1.3 – Unearned premium (MLR reporting year).

12/31 Column – report reserves established to account for the portion of the premium paid in the MLR reporting year that was intended to provide dental service coverage during the following MLR reporting year. Report the reserves as of 12/31 of the MLR reporting year, as reported to the regulatory authority of the health plan or health insurer for the MLR reporting year.

3/31 Column – report zero (note that if collected and due and unpaid premium is reported correctly in Line 1.1 above, Line 1.1 should not include amounts that would constitute unearned premium for dental service coverage in years subsequent to the MLR reporting year). However, if the health plan or health insurer chose to report direct written premium in Line 1.1 on the same basis as in the 12/31column, the health plan or health insurer should report unearned premium reserves consistently with how it reports direct written premium.

Line 1.4 – Premium write-offs.

Include:

- Agents' or premium balances determined to be uncollectible and written off as losses
- Recoveries made during the MLR reporting year on balances previously written
- Include actual write-offs

Exclude: Reserves for bad debt or statutory non-admitted amounts.

**Section 2 – Claims**

Amounts reported in Section 2 must include direct claims paid to or received by providers, including under capitation contracts with dental providers, whose services are covered by the contract for dental clinical services or supplies covered by the policy contract. Non-physician dental clinical providers must be licensed, accredited, or certified to perform dental clinical oral health care services, consistent with State law, and engaged in the delivery of dental services coverage to enrollees.

Incurred claims must include the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

Reimbursement for dental clinical services to enrollees is also referred to as incurred claims.

Include:

- Capitation Payments
- Incurred claims must include claims incurred but not reported based on past

experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity
- Incurred claims must include changes in other claims-related reserves
- Incurred claims must include incurred experience rating refunds
- Report payments net of risk share amount collected or paid
- Any overpayment that has not yet been recovered should be included in paid claims

Exclude:
- Amounts paid to third party vendors for secondary network savings
- Amounts paid to third party vendors for network development, administrative fees and profit, claims processing, and concurrent or post-service utilization management or any other health plan function
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered dental services provided to an enrollee
- Incentive and bonus payments made to providers (to be reported in Line 2.9)

Deduct:
- Any overpayment that has already been received and will be received from providers should not be reported as a paid claim

Line 2.1 – Claims paid.

2.1a – 12/31 Column – claims paid during the MLR reporting year regardless of incurred date.

2.2b – 3/31 Column – claims incurred only during the MLR reporting year, paid from 1/01 of the MLR reporting year through 3/31 of the following year.

Line 2.2 – Direct claim liability (MLR reporting year).

2.3a – 12/31 Column – liability as of 12/31 of MLR reporting year for all claims regardless of incurred date.

2.2b – 3/31 Column – liability based on claims incurred only during the MLR reporting year, and unpaid as of 3/31 of the following year.

Include:
- Unpaid claims, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation (including third party liability)
- Incurred but not reported – report claims incurred only during the MLR reporting year and not reported by 3/31 of the following year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to

reflect current conditions, such as changes in exposure

Line 2.3 – Direct claim liability prior year (year preceding the MLR reporting year).

12/31 Column – liability as of 12/31 of the year preceding the MLR reporting year, as reported to the regulatory authority of the health plan and health insurer for the year preceding the MLR reporting year.

Line 2.4 – Direct claim reserves (MLR reporting year).

2.4a – 12/31 Column – reserves as of 12/31 of MLR reporting year for all claims regardless of incurred date.

2.4b – 3/31 Column – reserves based on experience incurred only in the MLR reporting year, calculated as of 3/31 of the following year.

In addition, include claim reserves associated with claims incurred during the MLR reporting year. Report reserves related to dental services for present value of amounts not yet due on claims.

Line 2.5 – Direct claim reserves prior year (year preceding the MLR reporting year).

12/31 Column – reserves as of 12/31 of the year preceding the MLR reporting year, as reported to regulatory authority of the health plan or health insurer for the year preceding the MLR reporting year.

Line 2.6 – Experience rating refunds (rate credits) paid or received.

2. 6a – 12/31 Column – report all refunds paid or received through 12/31 of the MLR Reporting year.

2.6b – 3/31 Column – report refunds associated only with claims incurred during the MLR reporting year, paid or received through 3/31 of the following year.

Include: Experience rating refunds and State premium refunds paid or received during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention, and margin are less than earned premium.

Line 2.7 – Reserves for experience rating refunds (MLR reporting year).

2.7a – 12/31 Column – all refunds unpaid as of 12/31 of the MLR reporting year.

2.7b– 3/31 Column – refunds associated only with claims incurred during the MLR reporting year, not paid or received as of 3/31 of the following year.

Include: Reserves for experience rating refunds, plus reserves for State premium refunds.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 2.8 – Reserves for experience rating refunds (year preceding the MLR reporting year).

12/31 Column – as of 12/31 of the year preceding the MLR reporting year.

See instructions for Line 2.7.

Line 2.9 – Incurred dental incentive pools and bonuses.

12/31 Column – based on all payments through 12/31 of the MLR reporting year.

3/31 Column – based on amounts incurred only during the MLR reporting year and paid through 3/31 of the following year.

Include arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers.

2.9a – Paid dental incentive pools and bonuses for the MLR reporting year.

2.9b – Accrued dental incentive pools and bonuses for the MLR reporting year. Exclude amounts recorded on Line 2.9a, include only the amount of dental incentive and bonus pool payments that are estimated to be owed but not yet paid for the MLR reporting year.

2.9c – Accrued dental incentive pools and bonuses for the year preceding the MLR reporting year.

Line 2.10 – Contingent benefit and lawsuit reserves for claims incurred in the MLR reporting year.

12/31 Column – reserves as of 12/31 of the MLR reporting year.
If not separately reported in annual financial filings to the DMHC, the health plan or health insurer does not need to separately report this element in this column.

3/31 Column – reserves related to claims incurred during the MLR reporting year and unpaid as of 3/31 of the following year.
Health plan or health insurer must separately report this data element in the 3/31 column as provided in 45 CFR Part 158 and as noted in the General Instructions.

Include: The claims-related portion of reserves for contingent benefits and lawsuits.

Exclude: Reserves related to costs associated with claims lawsuits within Line 2.10; e.g. legal fees, court costs, pain and suffering damages, punitive damages, etc.

Line 2.11 Total incurred claims.

12/31 Column: Part 2 Lines 2.1a + 2.2a – 2.3 + 2.4a – 2.5 + 2.6a + 2.7a – 2.8 + 2. 9a + 2. 9b – 2. 9c + 2.10.

3/31 Column: Part 2 Lines 2.1b + 2.2b + 2.4b + 2.6b + 2.7b + 2.9a + 2.9b + 2.10.

# Instructions for MLR Annual Reporting Form − Part 3
# (Expense Allocation Methodology)

These MLR Form Filing Instructions only apply to the MLR reporting year and its reporting requirements.

Description of Methods to Allocate Expenses

Describe the methods used to allocate expenses, as reported on the MLR Form, including incurred claims, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, to each dental health insurance market (e.g., individual, small group, large group and by product type, each as defined in the Column Definitions at the beginning of these Filing Instructions).

A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated. (See instructions within Parts 1 and 2 for descriptions of the various expense elements.)

Acceptable Bases for Allocation of Expenses

Allocation of each type of expense among dental service insurance markets should be based on a generally accepted accounting method that is expected to yield the most accurate results. If this is not feasible, the health plan or health insurer should provide an explanation as to why it believes a more accurate result will be gained from its allocation of expenses, including pertinent factors or ratios, such as studies of employee activities, salary ratios or similar analysis.

Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management or administrative services contract, must be apportioned pro rata to the entities incurring the expense.

Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate to a specific entity or sub-set of entities, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by that specific entity or subset of entities and must not be apportioned to other entities within a group.

Line References

Line 1 – Incurred Claims (as reported on Part 2, Lines 2.1 through 2.10).

Line 2 – Federal and State Taxes and Licensing or Regulatory Fees (as reported on Part 1, Section 3).

Line 2.a – Federal taxes and assessments (as reported on Part 1, Lines 3.1a and 3.1b).

Line 2.b – State insurance, premium, and other taxes (as reported on Part 1, Lines 3.2a and 3.2b).
Line 2.c – Community benefit expenditures (as reported on Part 1, Line 3.2c).
Line 2.d – Regulatory authority licenses and fees (as reported on Part 1, Line 3.3).

Line 3 – Non-claims Costs (as reported on Part 1, Section 4)

Line 3.a – Direct sales salaries and benefits (as reported on Part 1, Line 4.1).
Line 3.b – Agents and brokers fees and commissions (as reported on Part 1, Line 4.2).
Line 3.c – Other taxes (as reported on Part 1, Lines 4.3a and 4.3b).
Line 3.d – Other general and administrative expenses (as reported on Part 1, Line 4.4).

## Instructions for MLR Annual Reporting Form – Part 4 (MLR Calculation)

These MLR Form Filing Instructions only apply to the MLR reporting year and its reporting requirements.

No data needs to be entered in any of the cells shaded grey or pink.

**COLUMN DEFINITIONS – PART 4**

Columns 1, 5, 9, 13, 17, 21 – **PY2**

> Report the information for the MLR reporting year that is two (2) years prior to the MLR reporting year. Report corrected amounts if reported in error in prior MLR Form submissions. All elements should be reported in accordance with the applicable reporting year's instructions. Exception: Part 4, Line 1.1 should be reported as originally submitted.

Columns 2, 6, 10, 14, 18, 22 – **PY1**

> Report the information for the MLR reporting year that is one (1) year prior to the MLR reporting year. Report corrected amounts if reported in error in prior MLR Form submissions. All elements should be reported in accordance with the applicable reporting year's instructions. Exception: Part 4, Line 1.1 should be reported as originally submitted.

Columns 3, 7, 11, 15, 19, 23 – **CY**

> Report the information for the MLR reporting year.

Columns 4, 8, 12, 16, 20, 24 – **Total**

> The Total column is used to calculate the numerator and denominator of the MLR calculation.

Column Groupings:

For the definitions for each of the following markets, see the Column Definitions at the beginning of these Filing Instructions.

Columns 1-4 – DHMO Products Individual Market
Columns 5-8 – DHMO Products Small Group Market
Columns 9-12 – DHMO Products Large Group Market
Columns 13-16 – DPPO & Indemnity Products Individual Market
Columns 17-20 – DPPO & Indemnity Products Small Group Market
Columns 21-24 – DPPO & Indemnity Products Large Group Market

## Section 1 – Medical Loss Ratio Numerator

Line 1.1 – Adjusted incurred claims as reported on the MLR Form for prior year(s):

PY2 Column – Report the information for the MLR reporting year that is two (2) years prior to the MLR reporting year, Part 1, Line 2.1, Columns 3/31.
For example: If the MLR reporting year is 2016, two (2) years prior to the MLR reporting year is 2014.

PY1 Column – Report the information for the MLR reporting year that is one (1) year prior to the MLR reporting year, Part 1, Lines 2.1, Columns 3/31.
For example: If the MLR reporting year is 2016, one (1) year prior to the MLR reporting year is 2015.

Line 1.2 – Adjusted incurred claims as of 3/31 of the year following the MLR reporting year:

Report corrected amounts if prior year's information was reported inaccurately.

PY2 Column – enter the amount of adjusted incurred claims reported on Part 1, Line 2.1, Columns 3/31 of the MLR Form two (2) years prior to the MLR reporting year, restated as of 3/31 of the year following the MLR reporting year. For example, for reporting year 2016, enter 2014 adjusted incurred claims restated as of 3/31/2017. (This is also known as claims incurred in 12 months and paid in 39 months.) Restate all applicable elements of adjusted incurred claims, including reserves, in accordance with the Filing Instructions from two (2) years prior to the MLR reporting year.

PY1 Column – enter the amount of adjusted incurred claims reported on Part 1, Line 2.1, Columns 3/31 of the MLR Form for the preceding MLR reporting year, restated as of 3/31 of the year following the MLR reporting year. (This is also known as claims incurred in 12 months and paid in 27 months). Restate all applicable elements of adjusted incurred claims, including reserves, in accordance with the Filing Instructions from the year preceding the MLR reporting year.

CY Column – Part 1, Lines 2.1

Line 1.3 – MLR numerator:

PY2 Column – Line 1.2
PY1 Column – Line 1.2
CY Column – Line 1.2
Total Column – Line 1.2

## Section 2 - Medical Loss Ratio Denominator

Line 2.1 – Premium earned:
PY2 Column – Report the information for the MLR reporting year that is two (2) years

prior to the MLR reporting year, Part 1, Line 1.1, Columns 3/31.
For example: If the MLR reporting year is 2016, two (2) years prior to the MLR reporting year is 2014.

PY1 Column – Report the information for the MLR reporting year that is one (1) year prior to the MLR reporting year, Part 1, Line 1.1, Columns 3/31.
For example: If the MLR reporting year is 2016, one (1) year prior to the MLR reporting year is 2015.

CY Column – Part 1, Line 1.1.

Line 2.2 – Federal and State taxes and licensing or regulatory fees:

PY2 Column – Report the information for the MLR reporting year that is two (2) years prior to the MLR reporting year, Part 1, Line 3.4, Columns 3/31.
For example: If the MLR reporting year is 2016, two (2) years prior to the MLR reporting year is 2014.

PY1 Column – Report the information for the MLR reporting year that is one (1) year prior to the MLR reporting year, Part 1, Line 3.4, Columns 3/31.
For example: If the MLR reporting year is 2016, one (1) year prior to the MLR reporting year is 2015.

CY Column – enter the result of the following calculation:

Federal tax-exempt health plan or health insurer:
Part 1, Line 3.4

Not Federal tax-exempt health plan or health insurer:
Part 1, Line 3.4

Line 2.3 – MLR denominator:

Total Column – enter the result of the following calculation:
Lines 2.1 – 2.2.

**<u>Section 3 – Credibility Experience</u>**

Line 3.1 – Life-years:

PY2 Column – Report the information for the MLR reporting year that is two (2) years prior to the MLR reporting year, Part 1, Line 5.3, Columns 3/31.
For example: If the MLR reporting year is 2016, two (2) years prior to the MLR reporting year is 2014.

PY1 Column – Report the information for the MLR reporting year that is one (1) year prior to the MLR reporting year, Part 1, Line 5.3, Columns 3/31.
For example: If the MLR reporting year is 2016, one (1) year prior to the MLR reporting year is 2015.

CY Column – Part 1, Line 5.3, Columns 3/31.

Non-credible experience: A health plan or health insurer with life-years of less than 1,000 as reported in Line 3.1, Total Column for the relevant market is exempted from MLR calculation requirements.

## Section 4 – Medical Loss Ratio Calculation

Health plans or health insurers with less than 1,000 life-years (Line 3.1, Total Column) are exempted from MLR calculation requirements.

Line 4.1 –Medical Loss Ratio:

Total Column – Line 1. 3 / Line 2.3, Total Column. Do not round.

## Instructions for MLR Annual Reporting Form – Part 5
## (Additional Responses)

These MLR Form Filing Instructions only apply to the MLR reporting year and its reporting requirements.

Line 1 – If the health plan or health insurer reported amount in Part 1, Line 3.2c, Community Benefit Expenditures, provide the state premium tax rate that was used in determining the reported amount.

Line 2 – If the health plan or health insurer included deferred experience for prior year and excluded deferred experience for current year, provide the total direct written premium and total incurred claims for the deferred experience by market.

Line 3 – If the health plan or health insurers novated any business in the MLR reporting year, and that novation was effective during the MLR reporting year, provide the name(s) of the entity(ies) to which the business was sold and the date of the sale or transfer.

## MLR Annual Reporting Form – Attestation Required by the DMHC

The officers of the reporting health plan are required to attest that this MLR Reporting Form and any supplemental submission that the health plan includes are full and true statements of the all the elements included therein for the MLR reporting year, and that the MLR Reporting Form has been completed in accordance with the DMHC's guidance and reporting instructions, according to the best of his/her information, knowledge and belief. Furthermore, the scope of this attestation by the described officer includes any related electronic filings and postings for the MLR reporting year stated above and which are required by the DMHC.