California Department of Managed Health Care
California Department of Insurance

Submission of Dental Methodology, Factors, and Assumptions (Assembly Bill 1048)

Final release date: 7/1/2024

Section I: Background.

Assembly Bill 1048 (Wicks. 2023, ch.557), requires health plans offering a specialized health care service plan contract covering dental services to file information regarding the methodology, factors, and assumptions used to determine rates with the Department of Managed Health Care (DMHC) annually and at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. The bill also requires health insurers offering specialized dental health insurance policies to file information regarding the methodology, factors, and assumptions used to determine rates with the Department of Insurance (CDI) annually and at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. Dental plans and insurers must file specified information by geographic region, provide certain actuarial certifications and meet specified consumer notice requirements.

Section II: Basis and Scope.

A. Basis. This document implements Health and Safety Code sections 1385.02, 1374.194 and 1385.14, relating to dental health care service plan contracts, and Insurance Code sections 10181.2, 10120.41 and 10181.14 relating to dental health insurance policies.

B. Scope. This document establishes the requirements for dental health care service plan filing requirements to ensure consistent and appropriate implementation of the Health and Safety Code sections 1385.02, 1374.194 and 1385.14, and the requirements for dental health insurance filings under Insurance Code sections 10181.2, 10120.41 and 10181.14.

Additional guidance may be forthcoming.

Section III: Definitions.

The following definitions apply unless otherwise specified.

A. “Community Rated” means a rating method in the dental market that bases rates on the expected costs to a health care service plan or health insurer for providing covered benefits to all enrollees or insureds, including both low-risk and high-risk enrollees or insureds. (H&SC § 1385.01 & CIC § 10181.) This is also commonly known as manually rated.

B. “Experience Rated” means a rating method in the group market under which a health care service plan or health insurer calculates the premiums for a group in whole or blended based on the group’s prior experience. (Ibid.)

C. “Blended” means a rating method that combines community rating and experience rating methods. (Ibid.)

D. “Methodology Change” includes, but is not limited to, a change from one of the three rating methods (Experience Rated, Community Rated or Blended) to another, or any change to the rating formula, credibility criteria, assumptions, or factors affecting the premium rates paid.

E. “Enrollee Cost Sharing” or “Insured Cost Sharing” means any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee or insured other than premium or share of premium.

F. “Geographic Region” has the same meaning as the geographic regions found in Health and Safety Code sections 1385.01(b)(1) & (2) and Insurance Code sections 10181(b)(1) & (2)

G. “Specialized health care service plan contract” means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, as defined in Health and Safety Code sections 1345(o).

H. “Specialized health insurance policy” means a policy of health insurance for covered benefits in a single specialized area of health care, including dental-only, vision-only, and behavioral health-only policies, as defined in Insurance Code section 106(c).

Section IV: Filing Requirements

These filing requirements apply to all dental filings submitted on or after January 1, 2025. Health plans and health insurers are required to submit a separate rate filing for each market (individual, small group, and large group).

The annual filing required by Health and Safety Code section 1385.14(b) or Insurance Code section 10181.14(b) must be submitted annually to the respective Department via SERFF on or before March 1. In the SERFF “Filing Description” line, indicate “Dental Methodology Annual Filing.”

Additionally, health plans and insurers must submit a Dental rate filing for any Methodology Change. This filing must be submitted to the respective Department via SERFF, no later than 120 days before implementing a Methodology Change. In the “Filing Description” line, indicate “Dental Methodology Change Filing.”

For community rated plan contracts and policies, please provide the proposed rate increase for all 12 months, and information regarding the methodology, factors, and assumptions used to determine rates for that entire period. For experience rated and blended plan contracts and policies, please provide the proposed rate increase for January and the coming renewal months, as well as information regarding the methodology, factors, and assumptions used to determine rates that are known at the time of filing.

A. For ***new products*** and/or ***existing products,*** the following spreadsheets, contained in the AB 1048 Dental Rate Review Workbook ("Dental Workbook") must be completed:

1. Cover-Input Page – Where most of the information will be filled out;
2. New_Product – Pricing information if a new product is being filed;
3. Existing_Product – Pricing information for products that already exist;
4. CA Rate Filing Spreadsheet;
5. CA Plain-Language Spreadsheet;
6. Price_Inflation – Allowed trends split into more granular detail, such as cost, utilization, etc.;
7. Avg Rate Changes – Rate changes in rating period by effective month;
8. Rating Factors & Methodology – Miscellaneous factors and data used to develop rates at the rate cell level. Additionally, address whether the rates were developed using experience rating or a blend, credibility threshold, etc.
9. Experience – 3-year data showing relevant incurred experience (including IBNP data) for the impacted plans;
10. Dental MLR Exhibit – The Dental MLR must be calculated separately for the large group, small group, and individual markets, and is an aggregation of a three-year historical period along with a two-year projection period (projection of remaining current year and next full rating period).
11. Checklist – Assists the reviewer with locating the various requested information (e.g., file name, page number, etc.)

The Dental Workbook must be submitted under the "Supporting Documentation" tab in SERFF as well as a separate spreadsheet containing rate information in response to questions within the Dental Workbook. This Dental Workbook can be found on the DMHC or the CDI.

The Department reserves the right to request additional information to supplement the information filed in the Dental Workbook, as necessary. Such a request may include, but isn't limited to, information regarding attained age versus issue age policies, anticipated loss ratios, renewability conditions, coverage options and availability for seniors.

B. Actuarial Certification

The certification required under Health and Safety Code sections 1385.14(b)(22) and 1385.06(b)(2) and Insurance Code sections 10181.14(b)(22) and 10181.6(b)(2) is a "Statement of Actuarial Opinion," as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a "Health Filing," as defined in Actuarial Standard of Practice No. 8, promulgated by the Actuarial Standards Board, and it is also an "Actuarial Communication," as defined in Actuarial Standard of Practice No. 41, promulgated by the Actuarial Standards Board.

The certification required under Health and Safety Code sections 1385.14(b)(22) and 1385.06(b) or Insurance Code sections 10181.14(b)(22) and 10181.6(b)(2) must include the following information:

1. A statement of the qualifications of the actuary issuing the certification. The actuary's qualifications must meet the standards stated in Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Health and Safety Code section 1385.06(b)(3) or Insurance Code section 10181.6(b)(3).

2. A statement of opinion that the proposed changes to affected rates in the filing are actuarially sound in aggregate for the particular market segment (i.e., large group, small group, or individual). The proposed changes to affected rates are actuarially sound if, for business in California and for the period covered by the certification, projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital reserves required by the Insurance Code or the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing at Health and Safety Code section 1340, et seq.

3. For each contract included in the filing, a complete description of the data, assumptions, rating factors and methods used, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract form included in the filing.

4. A description of the testing performed by the actuary to arrive at the statements of opinion in paragraph (2) above, including any independent rating models and rating factors utilized.

Section V: Public Availability

The DMHC and CDI will make submitted information publicly available except for contracted rates between a health plan or insurer and provider and contracted rates between a health plan or insurer and group pursuant to Health and Safety Code section 1385.07 and Insurance Code section 10181.7.

Section VI: Notice

No change in premium rates or changes in coverage stated in an individual or group health insurance policy shall become effective unless the health insurer has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date. (CIC §§ 10113.9, 10199.1.)