

REPORT OF MEDICAL LOSS RATIO EXAMINATION  
OF  
KAISER PERMANENTE INSURANCE COMPANY  
AS OF  
DECEMBER 31, 2014

Filed on March 10, 2017

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San Francisco, California  
December 9, 2016

Honorable Dave Jones  
Insurance Commissioner  
California Department of Insurance  
Sacramento, California

Dear Commissioner:

Pursuant to your instructions, a Medical Loss Ratio examination was made of the

**KAISER PERMANENTE INSURANCE COMPANY**

(hereinafter also referred to as the Company) at its home office located at 300 Lakeside Drive, 13th Floor, Oakland, California 94612.

**SCOPE OF EXAMINATION**

We have performed a Medical Loss Ratio (MLR) examination of the Company to determine compliance with California Insurance Code (CIC) Section 10112.25 related to minimum medical loss ratio requirements. CIC Section 10112.25 granted the Insurance Commissioner authority to adopt regulations to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (PHSA). Section 2718 of the federal PHSA authorized the U.S. Code of Federal Regulation (CFR) Title 45 – Public Welfare Part 158 to be implemented. This examination covered the reporting period from January 1, 2012 through December 31, 2014.

We performed procedures established by the U.S. Department of Health & Human Services (HHS) to examine the MLR Annual Reporting Form as completed by the Company and submitted to HHS for the 2012, 2013, and 2014 MLR reporting years, to ensure the validity of the underlying data, accuracy of the calculation, and accuracy and timeliness of the rebate payments made and reported in compliance with Title 45 CFR Part 158.

Title 45 CFR §158.403(a)(2) permitted HHS to accept the State's audit provided it, among other things, reports on the validity of the data regarding expenses and premiums that the issuer reported to the Secretary of HHS, including the appropriateness of the allocations of expenses used in such reporting and whether the activities associated with the issuer's reported expenditures for quality improving activities meet the definition of such activities. Title 45 CFR §158.403(a)(3) further permitted HHS to accept the State's audit provided it, among other things, reported on the accuracy of rebate calculations and the timeliness and accuracy of rebate payments.

### OWNERSHIP

The Company is a member of an insurance holding company system of which Kaiser Foundation Health Plan, Inc. (KFHP) is the ultimate controlling entity. The Company is a California insurance company whose voting stock is owned 50% by KFHP, a California non-profit public benefit corporation. The remaining 50% of the Company's voting stock is owned by the following Permanente Medical Groups: The Permanente Medical Group, Southern California Permanente Medical Group, Hawaii Permanente Medical Group, Northwest Permanente, P.C., Colorado Permanente Medical Group, P.C., Mid-Atlantic Medical Group, P.C., and The Southeast Permanente Medical Group. The Company has no subsidiaries. KFHP also owns 100% of the issued and outstanding preferred stock of the Company. The Company's shares are not publicly traded and there are no outside stockholders.

On October 1, 2013, the Ohio Permanente Medical Group, Inc. and its related health clinics were sold to Catholic Health Partners, a Company based in Cincinnati, Ohio. As a result of the sale, the Ohio Permanente Medical Group, Inc.'s 33.33 shares of the Company's issued and outstanding common stock were sold to the following affiliated medical groups:

Mid-Atlantic Permanente Medical Group, P.C	6.66 Shares
Northwest Permanente, P.C	6.66 Shares
The Southeast Permanente Medical Group	6.66 Shares
Hawaii Permanente Medical Group	6.66 Shares
Colorado Permanente Medical Group, P.C.	6.66 Shares

After these sales and purchases, Mid-Atlantic Permanente Medical Group, P.C., Northwest Permanente, P.C., The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, and Colorado Permanente Medical Group, P.C. each own 39.984 shares of the Company's common stock, representing 4.16% of the Company's issued and outstanding shares of common stock. No other changes to the interrelationships of the Company to KFHP and the Permanente Medical Groups occurred since the sale of the Ohio Permanente Medical Group, Inc.

Effective July 1, 2012, the Company ceased actively marketing and selling its Exclusive Provider Option Customer Select Individual (CSI) Plan. The California Department of Insurance approved the CSI plan on September 15, 2008. The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) required that maternity coverage be included in all health insurance policies. The CSI product was intended as a lower cost plan for individuals who are interested in obtaining affordable health insurance coverage but did not want maternity coverage. The Company made the decision to cease actively marketing and selling of new CSI contracts as of July 1, 2012 to comply with ACA. On December 31, 2013, the discontinuation of the CSI plan was completed.

### TERRITORY AND PLAN OF OPERATION

The Company jointly markets its indemnity health and dental products alongside Kaiser Foundation Health Plan, Inc. (KFHP)'s prepaid health care plans. The Company uses the same sales force employed by KFHP. The Company offers point-of-service (POS); preferred provider organization option (PPO); out-of-area health (OOA); exclusive provider organization product (EPO); and dental coverage. The POS product is a single benefit product with three tiers: medical services through prepaid group coverage to be provided by KFHP, medical services through a national contracted provider network or medical services through any licensed non-participating provider. The PPO option offers the members within an employer group referral-free access to a private healthcare system network of participating providers or any other licensed provider nationwide.

The Company's OOA product consists of indemnity health care coverage to subscribers who do not live in KFHP's service area, but live in the United States. The Company's EPO product is an individually underwritten group plan which provides exclusive benefits and services utilizing KFHP's provider network. KFHP providers bill the Company on a fee-for-services basis for medical and surgical services provided to the EPO organization.

The Company is an administrator for Kaiser Permanente's Self-Funded Program. Each self-funded plan, through its plan sponsor, will contract with the Company to provide administrative services only (ASO) for the self-funding plan. The Company contracts with Harrington Health, a Third Party Administrator, to provide certain administrative services for Kaiser Permanente's Self-Funded Program such as claims processing, eligibility information and benefits.

The Company offers Specific Excess of Loss and Aggregate Excess of Loss Insurance for employers with self-funded employee health benefit plans. Under Specific Excess of Loss Insurance, the employer is insured against large individual claims in excess of the specified deductible. Under Aggregate Excess of Loss Insurance, the employer is insured against excessive health care costs for its entire covered employee pool. The excess of loss insurance is only available to plan sponsors who are a part of Kaiser Permanente's Self-Funded Program and not available to outside self-funded plan sponsor.

The Company is licensed to write business in the following 12 states and the District of Columbia: California, Colorado, Georgia, Hawaii, Kansas, Maryland, Missouri, Ohio, Oregon, South Carolina, Virginia, and Washington. For the year ending December 31, 2014, the Company wrote in California, Colorado, Georgia, Hawaii, Maryland, Ohio, Virginia, and District of Columbia with the majority of direct premium (53.3%) generated in California.

MEDICAL LOSS RATIO REPORTING FORM

Title 45 of the U.S. Code of Federal Regulations (CFR) §158.110(b) requires that a report for each Medical Loss Ratio (MLR) reporting year be submitted to the Secretary of the U.S. Department of Health and Human Services (HHS). For reporting years 2011, 2012, and 2013, the reports must be submitted to the HHS by June 1st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the HHS. Beginning with the 2014 MLR reporting year, the report for each MLR reporting year must be submitted to HHS by July 31st of the year following the end of an MLR reporting year, on a form and in the manner prescribed by HHS.

Based on our review of the filing, the Company filed an acceptable form by July 1, 2015 for the 2014 reporting year and is in compliance with Title 45 CFR §158.110(b).

Title 45 CFR §158.210(a) requires that an issuer must provide a rebate to enrollees if the issuer has a MLR of less than 85% for the large group market. Title 45 CFR §158.210(b) and (c) require that an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80% for the small group market and the individual market. The Company's MLR and rebate calculations from the 2014 MLR Annual Reporting Form, Part 4, for California are as follows:

<b>MLR Components</b>	<b>Individual</b>	<b>Small Group</b>	<b>Large Group</b>	<b>Notes</b>
Adjusted Incurred Claims	\$159,305,013	\$14,041,476	\$71,426,766	
Plus: Quality Improvement Expenses	\$0	\$0	\$0	
Less: Federal Risk Adjustment program charges payable to HHS	\$0	\$(178,209)	\$0	
MLR Numerator				
Premium Earned	\$209,847,438	\$19,811,823	\$73,108,481	
Less: Federal & State Taxes and Licensing or Regulatory Fees	\$6,135,918	\$1,913,962	\$(420,519)	
MLR Denominator	\$203,711,520	\$17,897,861	\$73,529,000	(2)

<b>MLR Components (Continue)</b>	<b>Individual</b>	<b>Small Group</b>	<b>Large Group</b>	<b>Notes</b>
Preliminary MLR Before Credibility Adjustment	78.2%	79.5%	97.1%	
Credibility Adjustment	0.0%	5.1%	2.9%	(3)
Credibility-Adjusted MLR	78.2%	84.6%	100.0%	(4)
MLR Standard	80.0%	80.0%	85.0%	
Rebate Amount	\$0	\$0	\$0	(5)

Based on our examination, the Company did not owe any rebates for the MLR Reporting Year 2014 in any of the markets. However, the Company owed rebates for MLR Reporting Years 2012 and 2013 for the individual market.

#### COMMENTS ON MEDICAL LOSS RATIO CALCULATION

##### (1) Medical Loss Ratio Numerator

According to the U.S. Code of Federal Regulations (CFR), Title 45, §158.221(b), the numerator of the Medical Loss Ratio (MLR) calculation is comprised of incurred claims, as defined in Title 45 CFR §158.140, plus expenditures for activities that improve health care quality, as defined in Title 45 CFR §158.150, and Title 45 CFR §158.151. We reviewed and verified the data used to calculate the adjusted incurred claims. Based on our review, the Company included appropriate adjusted incurred claims in the MLR numerator. The Company did not report any health care quality improvement expenses.

(a) The Company included a transitional adjustment amount of \$428.00 in the MLR Numerator. As the amount was not significant, no exception was noted.



## (2) Medical Loss Ratio Denominator

According to Title 45 CFR §158.221(c), the denominator of the MLR calculation is comprised of issuer's premium revenue, as defined in Title 45 CFR §158.130, excluding federal and state taxes, and licensing and regulatory fees, described in Title 45 CFR §158.161(a), and Title 45 CFR §158.162(a)(1) and (b)(1) and after accounting for payments or receipts related to risk adjustment, risk corridors, and reinsurance, described in Title 45 CFR §158.130(b)(5). We reviewed and verified the data used to calculate the premium revenue. Based on our review, the Company included appropriate premiums earned in the MLR denominator.

We reviewed the reasonableness and appropriateness of the federal and state taxes, and regulatory fees including the appropriateness of allocations and the definition of such activities. Based on our review, the Company's allocation methodology and federal and state taxes, and regulatory fees reported in the MLR denominator are reasonable and conform to the regulations.

## (3) Credibility Adjustment

According to Title 45 CFR §158.232, the credibility adjustment is the product of the base credibility factor multiplied by the deductible factor. For MLR Reporting year 2014, the Company's small and large group markets were partially credible with credibility factor of 5.1% and 2.9%, respectively. The components used to calculate the base credibility and deductible factors were reviewed without exceptions. Based on our review, the Company appropriately calculated and applied the credibility adjustments.

The Company's health plans do not require any deductibles; therefore, the Company did not apply any deductible factors.

#### (4) Credibility Adjusted Medical Loss Ratio

According to Title 45 CFR §158.221(a), the calculation of MLR is the ratio of the numerator to the denominator, subject to the applicable credibility adjustment, if any. Based on our review, it appears that the Company appropriately calculated the MLR for each market segment.

#### (5) Rebate Amount

According to Title 45 CFR §158.240, an issuer must provide a rebate if the issuer's MLR does not meet or exceed the minimum percentage required for the applicable market segment. Based on our review, the Company's MLR for the reporting year 2014 exceeded the minimum percentage for small and large market segments. The Company did not have any policies in the individual market in 2013 or 2014 as it was discontinued in 2012.

### NOTICE OF REBATE

According to Title 45 of the U.S. Code of Federal Regulations §158.250(a) and (b), a notice of rebate is required when the medical loss ratios do not exceed the minimum percentage. Based on our review, the Company's medical loss ratios for MLR reporting year 2014 exceeded the minimum percentage for the small and large market segments and no rebates were issued.

The Company issued rebates for MLR reporting years 2012 and 2013 for the individual market segment. Based on our review, the Company issued rebate notices appropriately and timely.

### REBATE PAYMENTS ON SOLVENCY

According to Title 45 of the U.S. Code of Federal Regulations §158.270(a), rebate payments having any adverse impact to the Company's Risk Based Capital (RBC) level

requires notification by the California Department of Insurance to the Secretary of the U.S. Department of Health & Human Services (HHS). Based on our review, the Company's MLRs exceeded the minimum percentage for the small and large group market segments for MLR reporting year 2014, and no rebates were issued. Therefore, there was no adverse impact on the RBC level that would warrant notification to the Secretary of HHS.

The Company's MLR did not exceed the minimum percentage for the individual market segment for MLR reporting years 2012 and 2013. Therefore, the Company issued rebates for the individual market segment in MLR reporting years 2012 and 2013. The rebates did not have an adverse impact on the RBC level that would warrant notification to the Secretary of HHS.

#### SUMMARY OF COMMENTS AND RECOMMENDATIONS

##### Current Report of Examination

None

##### Previous Report of Examination

None

ACKNOWLEDGMENT

Acknowledgment is made of the cooperation and assistance extended by the Company's officers and employees during the course of this examination.

Respectfully submitted,

/S/ \_\_\_\_\_

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/S/ \_\_\_\_\_

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