March 31, 2014

The Honorable Nancy Skinner
California State Assembly
State Capitol, Room 6026
Sacramento, CA 95814

Re: **Opposition to AB 1962**

Dear Assembly Member Skinner:

The National Association of Dental Plans (NADP) is providing comments in opposition to AB 1962 which requires loss ratios of 80% to 85% on small and large group dental plans respectively. While the bill as proposed seems to provide additional protections to California consumers on dental premiums, in practice it does the opposite.

Medical loss ratios are designed to require a certain percentage of an enrollee's premium to be paid towards health services, not a carrier's administrative expenses and profit. While designed to do the same, a dental loss ratio is necessarily lower because; dental premiums are 1/12 of medical premiums and dental plans have similar administrative costs to those of medical plans. Generally, states do not apply loss ratios to dental plans but utilize the detailed financial reports filed with regulators to examine carriers' financial solvency and overall value provided to enrollees. When loss ratios have been applied to dental plans, they are significantly lower than medical ratios, and the methodology for coming into compliance is usually an administrative plan worked out with the regulators, not individual payments to consumers. Given dental's low premium amounts, payments or rebates to consumers could be pennies with administrative expenses to process many times the actual payment.

To fully understand the repercussions of AB 1962, NADP commissioned Milliman to provide an impartial actuarial analysis. The memo indicates the following:

- "Dental insurers perform largely the same functions as medical insurers, including claim payment, customer service, marketing and sales, billing and collection of premiums, and other business critical activities. They are also generally subject to taxes and fees just as health insurers are. The significant premium differential

National Association of Dental Plans
12700 Park Central Drive • Suite 400 • Dallas, Texas 75251
972.458.6998 • 972.458.2258 [fax]

between dental and medical insurance makes it reasonable to expect lower minimum loss ratios for dental insurance than for medical, as the expense to support substantially similar underlying business activities must be recouped over a much smaller premium base."

- "To keep the administrative expenses constant while complying with a higher minimum loss ratio requirement**, the DHMO carrier may have no other alternative but to increase claim costs – i.e., the capitation and supplemental payments paid to providers.** This seems counterintuitive and would give providers additional compensation and increase premiums while providing no additional benefit to consumers. However, **to mathematically achieve a higher minimum loss ratio while maintaining the needed administrative expense level, increasing claim costs would be the only solution."**
- The scenarios laid out by Milliman… "would indicate DHMO would have to pay providers significantly more to comply with the ACA loss ratio requirement without reducing administrative costs. This result would increase premiums to the consumer considerably and would increase provider payments significantly."

The memo clearly indicates there is little to "squeeze out" of administrative and/or profit margins for dental carriers to hit a medical loss ratio. The only way to reach an 85%/80% loss ratio will be to increase payments to providers at the expense of higher premiums for employers and consumers- thus the enormous support by the California Dental Association.

Milliman is in the process of developing a memo modeling the impacts on dental PPOs. While the results are not complete at the time for submission of this letter, they have verbally indicated that the results for DPPOs that provide coverage for small employers of 50 or fewer employees are similar to the results for DHMOs. Small employers thus would be hit hardest by increased costs for both DHMOs and DPPOs.

For DHMOs to reach an 80% or 85% loss ratio, Milliman estimates premium increases would range from

- 178% to 337% when the DHMO starts from a 50% loss ratio (with a corresponding increase in payments to providers of 320% to 606%)
- 140% to 277% when the DHMO starts from a 55% loss ratio (with a corresponding increase in payments to providers of 229% to 453%)
- 102% to 218% when the DHMO starts from a 60% loss ratio (with a corresponding increase in payments to providers of 153% to 326%)
- 64% to 158% when the DHMO starts from a 65% loss ratio (with a corresponding increase in payments to providers of 89% to 219%)

NADP's latest Dental Benefits Report: Financial Operations 2013 shows that payments to providers, the largest element of dental loss ratios, average 57.7% for small group DHMOs and 67% for dental PPOs. This clearly illustrates that 80% and 85% for all dental products is unreasonable.

The California Dental Association, as sponsor of the bill, had the Blue Sky Consulting Group[1] provide a policy report on dental loss ratio. Their report includes these statements which support our observations:

[1] This analysis included data from an NADP report without purchasing the report or requesting copyright permission.

- "Because dental plans have much lower premium revenues per customer relative to health plans, larger fixed costs and larger per customer costs can increase administration expenses as a percent of premiums collected."
- There is potential for loss ratios to destabilize insurance markets.
- If California moves toward a dental loss ratio… "the minimum loss ratio should be set at a level lower than that established for health plans," and even indicated that loss ratios as low as 42 percent could be considered reasonable.

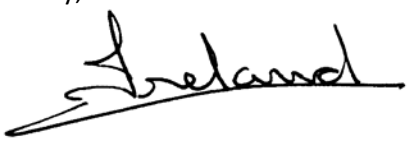
Looking at various reports on dental loss ratios within California, legislators must question the actual results that will occur if AB 1962 is enacted as proposed and question whether the bill actually assists consumers. Dental carrier's administrative costs and profit margins are as minimal as they can be made, and therefore the bill simply increases premiums for consumers while increasing providers' payments.

NADP members anticipate that with the passage of AB 1962, and the ensuing significant premium increases, employers and consumers alike will drop coverage. While small employers may have to continue coverage for children to meet ACA requirements, there is no similar requirement for adults.

California could be left with a significant decrease in the population with dental coverage resulting in decreased dental care and lower overall dental health. California regulators review financial reports, and process dental complaints from consumers. In general dental carriers are applauded by regulators for minimal consumer complaints overall as an industry. This brings into question whether the genesis of AB 1962 is consumer interest or provider interest. We believe the bill is unnecessary and a detriment to your constituents.

NADP is appreciative for the opportunity to provide comments on AB 1962, and is happy to provide further information as NADP maintains and collects a substantial range of information on the dental benefit industry. For additional information, attached is the Milliman memo relating to impact of the proposed loss ratios on dental HMOs; a similar memo relating to dental PPOs will be ready by the time of your hearing and will be filed at that time. Also I have attached a listing of NADP's member companies. Please contact me with any questions regarding these comments at eireland@nadp.org or (972) 458-6998 x101. Again, thank you for your consideration.

Sincerely,



Evelyn F. Ireland, CAE
Executive Director, National Association of Dental Plans

CC: Members of the Committee

National Association of Dental Plans
12700 Park Central Drive • Suite 400 • Dallas, Texas 75251
972.458.6998 • 972.458.2258 [fax]

NADP DESCRIPTION

NADP is the largest non-profit trade association focused exclusively on the dental benefits industry, i.e. dental PPOs, dental HMOs, discount dental plans and dental indemnity products. NADP's members provide dental benefits to approximately 90 percent of the 187 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

National Association of Dental Plans

12700 Park Central Drive • Suite 400 • Dallas, Texas 75251

972.458.6998 • 972.458.2258 [fax]

80 Lamberton Road
Windsor, CT 06095
USA

Tel +1 860 687 2110
Fax +1 860 687 2111

milliman.com

MEMO

Joanne Fontana, FSA, MAAA
Consulting Actuary

joanne.fontana@milliman.com

TO: Evelyn Ireland, CAE
Executive Director
National Association of Dental Plans

FROM: Joanne Fontana

DATE: March 18, 2014

RE: Illustrative Impact of Minimum Loss Ratio Regulation on Dental HMO Claim Costs

BACKGROUND AND PURPOSE

Under the Patient Protection and Affordable Care Act (ACA), health care service plans and health insurers must comply with specified minimum loss ratio requirements. The ACA loss ratio calculation is modified from the traditional "claim costs divided by premium" loss ratio, allowing quality improvement expenses to be included in the numerator and taxes and fees to be subtracted out of the denominator. If the ACA minimum loss ratio requirements are not met, insurers must provide an annual rebate to enrollees. The law excludes specialized health care service plan contracts and specialized health insurance policies such as standalone dental plans. However, California bill AB1962 aims to extend the ACA minimum loss ratio requirements to dental health care service contracts and dental health insurance policies in the state. Plans offering coverage in the large group market would be subject to a minimum loss ratio of 85%, while plans in the small group or individual market would be subject to an 80% minimum loss ratio. The National Association of Dental Plans (NADP) has asked Milliman to perform some illustrative calculations, using a sample dental HMO (DHMO) plan operating in California, showing the impact on premiums and on provider capitation rates when the minimum loss ratio requirements are applied.

SUMMARY OF KEY RESULTS

Primer on ACA Medical Loss Ratio Calculation

Traditionally, loss ratios are expressed as

Loss Ratio = Claim Costs/Premium,

representing the proportion of premium spent directly on the cost of care via payments to providers.

However, under the ACA, the calculation of loss ratios to be used in determining compliance with minimum loss ratio regulations is broadly defined as:

ACA Loss Ratio = (Claim Cost + Quality Improvement Expenditures)/
(Earned Premiums – Taxes, Licensing, and Regulatory Fees)

The ACA Loss Ratio differs from the traditional definition in the following ways:

- Quality improvement expenditures (QIE) must be included in the numerator.
- Taxes, licensing, and regulatory fees must be subtracted from the denominator.

The calculation of a medical plan's loss ratio is complicated; specific rules govern what types of QIE qualify as an addition to claim costs and what types of taxes and fees qualify as reductions to earned premiums. QIE are expenditures for activities conducted by an issuer designed to:

- improve health quality
- increase the likelihood of desired health outcomes in measurable ways
- be directed toward individual enrollees or incurred for the benefit of the enrolled population
- be grounded in evidence based medicine and clinical best practices

Some activities are expressly prohibited from being counted as QIE, including those that:

- are primarily focused on containing cost
- benefit self-funded plans
- are paid for with revenue other than premiums
- are reimbursable to providers as clinical services
- are concerned with maintaining claims adjudication systems
- are concerned with retrospective or concurrent utilization review
- involve developing or executing on provider contracts, maintaining provider networks, or credentialing providers

Also, further adjustments may be made to a medical plan's loss ratio based on the credibility of a given plan due to low enrollment levels and/or high deductible levels, using rules contained in 45 CFR 158 of the ACA.

It is unclear how exactly these provisions would be expected to apply to dental plans in AB1962. For purposes of this memo, we have made assumptions regarding the value of QIE which may need to be refined if the bill's loss ratio calculation methodology is further defined. We have also made assumptions regarding the value of the taxes, licensing, and regulatory fees, which may also need to be adjusted upon further refinement of the bill.

Impact of Minimum Loss Ratio on Illustrative Dental HMO: Methodology and Results

Initial Assumptions

We started with an illustrative DHMO plan using the following assumptions, agreed upon with NADP as representative of the California DHMO market:

- $12.00 per member per month (PMPM) premium
- $1.20 PMPM commission, equivalent to a 10% commission assumption
- $0.36 PMPM profit, equivalent to a 3% profit assumption

Due to variation in prevailing loss ratios among carriers, we generated 4 starting point claim costs PMPM and PMPM administrative expense assumptions under 4 different traditional loss ratio scenarios, as

shown in Table I. The starting PMPM claim cost is calculated simply as ($12 PMPM premium x Loss Ratio). The starting administrative cost assumption is then calculated as ($12.00 PMPM premium - $1.20 PMPM commission - $0.36 PMPM profit – PMPM claim cost).

TABLE I. Initial Claim Cost and Administrative Expense Assumptions by Assumed Prevailing Loss Ratio

Starting Loss Ratio	50%	55%	60%	65%
Claim Cost PMPM	$6.00	$6.60	$7.20	$7.80
Administrative Expense PMPM	$4.44	$3.84	3.24	$2.64

To calculate the ACA loss ratio, we made the following additional assumptions:

- Quality improvement expenditures equal to $0.40 PMPM (estimated; assumed to represent approximately 3% of initial $12 premium)
- Taxes, licensing, and regulatory fees equal to 4% of premium (estimated; includes ACA issuer fee, exchange fees, and other licensing and regulatory fees, and 0% premium tax)

Modeling of Minimum Loss Ratio Impact

NADP asked Milliman to assume that, if a minimum loss ratio requirement were applied to the DHMO, the DHMO plan would not be able to compensate by lowering its administrative expense allowance. It is assumed that the DHMO is already operating efficiently, and that due to the DHMO's very low premium level, it is necessary to allocate a significant portion of the premium toward operation of the plan. We believe this to be a reasonable assumption. Dental insurers perform largely the same functions as medical insurers, including claim payment, customer service, marketing and sales, billing and collection of premiums, and other business critical activities. They are also generally subject to taxes and fees just as health insurers are. The significant premium differential between dental and medical insurance makes it reasonable to expect lower minimum loss ratios for dental insurance than for medical, as the expense to support substantially similar underlying business activities must be recouped over a much smaller premium base. According to the Covered California Health Plans Booklet released May 24, 2013, the statewide average premium for the Silver medical plan to be offered on the individual exchange is $321 per month; this premium can be compared the $12 dental premium above. Even an 80% loss ratio on this medical premium would result in the medical insurer having $64.20 per member per month for administration and other expenses, several multiples higher than the dental administrative expenses and five times the entire dental premium shown in Table I. With dental insurers' significantly lower premium levels off which to recoup expenses to perform functions similar to a medical carrier, a lower dental target loss ratio would be expected. In addition, in California in particular, dental HMOs are subject to a rigorous quality, financial, and administrative review every three years by the Department of Managed Health Care, enabling strides in quality and administrative efficiency well ahead of the DHMO market nationwide.

To keep the administrative expenses constant while complying with a higher minimum loss ratio requirement, the DHMO carrier may have no other alternative but to increase claim costs – i.e., the capitation and supplemental payments paid to providers. This seems counterintuitive and would give providers additional compensation and increase premiums while generally providing no additional benefit to consumers. However, to mathematically achieve a higher minimum loss ratio while maintaining the needed administrative expense level, increasing claim costs would be the only solution. Modeled below in Tables IIa – IId is the impact on claim costs and premiums of various minimum loss ratio requirements ranging from 70% to 85%. The loss ratio was assumed to be calculated on an ACA basis; taxes, licensing and regulatory fees were subtracted from premium in the denominator and quality improvement

expenses were included in the numerator. Commissions were assumed to be paid on a percent-of-premium basis; as premiums increase, commissions were assumed to increase as well. It was assumed that taxes and fees were also levied on a percent of premium basis and will vary as premiums vary. Profit was assumed to stay constant at $0.36 PMPM; profit was not increased as premiums vary.

TABLE IIa. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Holding Administrative Expenses Constant
(Starting Point: 50% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$42.37	$52.41	$42.77	$50.31	$36.37	$40.41	606%	337%
80%	$25.21	$33.34	$25.61	$32.01	$19.21	$21.34	320%	178%
75%	$17.21	$24.45	$17.61	$23.47	$11.21	$12.45	187%	104%
70%	$12.57	$19.30	$12.97	$18.53	$6.57	$7.30	110%	61%

TABLE IIb. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Holding Administrative Expenses Constant
(Starting Point: 55% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$36.50	$45.22	$36.90	$43.41	$29.90	$33.22	453%	277%
80%	$21.70	$28.78	$22.10	$27.63	$15.10	$16.78	229%	140%
75%	$14.80	$21.11	$15.20	$20.27	$8.20	$9.11	124%	76%
70%	$10.80	$16.67	$11.20	$16.00	$4.20	$4.67	64%	39%

TABLE IIc. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Holding Administrative Expenses Constant
(Starting Point: 60% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$30.69	$38.10	$31.09	$36.58	$23.49	$26.10	326%	218%
80%	$18.22	$24.24	$18.62	$23.27	$11.02	$12.24	153%	102%
75%	$12.40	$17.78	$12.80	$17.07	$5.20	$5.78	72%	48%
70%	$9.03	$14.03	$9.43	$13.47	$1.83	$2.03	25%	17%

TABLE IId. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Holding Administrative Expenses Constant
(Starting Point: 65% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$24.85	$30.94	$25.25	$29.70	$17.05	$18.94	219%	158%
80%	$14.73	$19.70	$15.13	$18.91	$6.93	$7.70	89%	64%
75%	$10.00	$14.44	$10.40	$13.86	$2.20	$2.44	28%	20%
70%	$7.26	$11.40	$7.66	$10.95	-$0.54	-$0.60	-7%	-5%

The carrier would need to derive the premium level that would allow for the administrative costs to remain at their current level while complying with the minimum loss ratio requirement as calculated according to the ACA loss ratio formula. For example, for a carrier currently operating at a 50% loss ratio, to comply with an 85% ACA minimum loss ratio requirement while maintaining an administrative expense allowance of $4.44 (as shown in Table I), the carrier would have to increase claim costs by $36.37 PMPM or by 606%. While we illustrated one example from the 4 tables above, you can see that in virtually all scenarios, claim costs are increased significantly over their prior levels.

This would indicate that the DHMO would have to pay providers significantly more to comply with the ACA loss ratio requirement without reducing administrative costs. This result would increase premiums to the consumer considerably and would increase provider payments significantly. In some instances the DHMO could increase the richness of the benefit plan design to provide at least some value to the consumer along with the increased premiums, where not constrained by regulation such the individual and small group actuarial value requirements on pediatric dental plans. However, even if benefit adjustments are made, the price increases shown in the tables above are likely to make the product's value to the consumer decline, making other lower-priced offerings such as dental discount plans more attractive.

Alternate Scenario

We also modeled an alternative scenario in which the following assumptions were altered from the scenario just described.

- Commissions were assumed to stay constant at $1.20 PMPM rather than rising along with premium levels. We used this alternate assumption in case the imposition of a minimum loss ratio causes carriers to attempt to reduce producer compensation to help mitigate the impact of the required loss ratio. While this could happen to some extent, it is more difficult to adjust producer compensation for low-premium products like dental insurance than for medical insurance.
- We assumed that DHMO carriers would reduce their administrative expenses by 15% from the numbers shown in Table I. We believe that such a reduction would require aggressive actions for most DHMO carriers, some of which could have a negative impact on consumer facing activities such as customer service and quality assurance. However, to the extent that any administrative expense reductions are attainable, we wanted to include a scenario with some administrative expense impact.

Tables IIIa – IIId show the results for this alternate scenario.

TABLE IIIa. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Assuming Constant Commissions and Administrative Expense Reduction of 15%
(Starting Point: 50% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$21.49	$26.82	$21.89	$25.75	$15.49	$14.82	258%	124%
80%	$15.94	$21.27	$16.34	$20.42	$9.94	$9.27	166%	77%
75%	$12.29	$17.62	$12.69	$16.92	$6.29	$5.62	105%	47%
70%	$9.71	$15.04	$10.11	$14.44	$3.71	$3.04	62%	25%

TABLE IIIb. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Assuming Constant Commissions and Administrative Expense Reduction of 15%
(Starting Point: 55% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$19.22	$24.04	$19.62	$23.08	$12.62	$12.04	191%	100%
80%	$14.25	$19.07	$14.65	$18.31	$7.65	$7.07	116%	59%
75%	$10.98	$15.80	$11.38	$15.17	$4.38	$3.80	66%	32%
70%	$8.66	$13.49	$9.06	$12.95	$2.06	$1.49	31%	12%

TABLE IIIc. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Assuming Constant Commissions and Administrative Expense Reduction of 15%
(Starting Point: 60% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$16.96	$21.27	$17.36	$20.42	$9.76	$9.27	136%	77%
80%	$12.56	$16.87	$12.96	$16.20	$5.36	$4.87	74%	41%
75%	$9.67	$13.98	$10.07	$13.42	$2.47	$1.98	34%	17%
70%	$7.62	$11.93	$8.02	$11.46	$0.42	-$0.07	6%	-1%

TABLE IIId. Impact on DHMO PMPM Claim Costs and Premiums of Increasing Minimum Loss Ratio, Assuming Constant Commissions and Administrative Expense Reduction of 15%
(Starting Point: 65% Loss Ratio)

Assumed ACA LR Require-ment	Claim Cost PMPM	Prem. PMPM	ACA LR Numerator (Claim Cost + QIE)	ACA LR Denominator (Premium – Taxes/Fees)	Incr. in Claim Cost PMPM	Incr. in Prem. PMPM	% Incr. in Claim Cost	% Incr. in Prem.
85%	$14.70	$18.50	$15.10	$17.76	$6.90	$6.50	88%	54%
80%	$10.87	$14.67	$11.27	$14.08	$3.07	$2.67	39%	22%
75%	$8.35	$12.16	$8.75	$11.67	$0.55	$0.16	7%	1%
70%	$6.57	$10.38	$6.97	$9.96	-$1.23	-$1.62	-16%	-14%

As you can see, even under this alternative, much more aggressive scenario, the carrier would still need to substantially increase claim costs and premiums to comply with the minimum loss ratio requirement. For example, for a carrier currently operating at a 50% loss ratio, to comply with an 85% ACA minimum loss ratio requirement while maintaining an administrative expense allowance of $3.77 ($4.44 shown in Table I reduced by 15%), the carrier would have to increase claim costs by $15.49 PMPM or by 258%. Even if the carrier were to enrich the dental benefit plan to fully cover all services, the claim cost would not rise enough to be compliant with the minimum loss ratio; the only way to comply would be to increase payments to providers, and premiums paid by consumers, without commensurately increasing benefits to those consumers.

The results presented in this report are illustrative and do not mimic the actual experience of any particular DHMO plan. They are meant to demonstrate the mechanics of complying with minimum loss ratio rules while maintaining a specified administrative expense structure, and the implications to claim costs and premiums of doing so. It is important to note that results will differ if the starting assumptions differ, or if other levers aside from provider compensation are adjusted (e.g. if profit level ere altered in response to the increased loss ratio requirement). In addition, results will differ for higher premium policies like dental PPOs.

CAVEATS AND LIMITATIONS

I, Joanne Fontana, am a Consulting Actuary for Milliman. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Milliman has prepared this report for the specific purpose of providing sample loss ratio calculations for DHMO plans. This information may not be appropriate, and should not be used, for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of NADP. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work even if we permit the distribution of our work product to such third party.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by NADP. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Milliman does not provide legal advice, and recommends that NADP consult with its legal advisors regarding legal matters.

The terms of Milliman's Consulting Services Agreement with NADP dated March 17, 2011 and signed March 24, 2011 apply to this letter and its use.

NADP MEMBERS & SUBSIDIARIES

Last Updated: February 2014

Advantage Dental Plan
Aetna Dental
Altus Dental Ins Co
Delta Dental of RI
American Dental Professional Svcs
American Dental Partners
American Enterprise Group
AmeriPlan Corporation
Ameritas Life Ins Corp.
First Ameritas Life Ins Corp.
Argus Dental Plan, Inc.
Assurant Employee Benefits
Dental Health Alliance, LLC
DentCare, Inc. a Kentucky corporation
DentiCare of Alabama, Inc.
DentiCare of Oklahoma, Inc.
DentiCare, Inc. a Florida corporation
First Fortis Life Ins Co
Fortis Benefits DentalCare of New Jersey In
Fortis Benefits DentalCare of WI, Inc.
Fortis Benefits Ins Co
Fortis Dental Benefits
Georgia Dental Plan, Inc.
UDC Life and Health Ins Co
Union Security Life Ins Co of NY
United Dental Care Ins Co
United Dental Care of Arizona, Inc.
United Dental Care of Colorado, Inc.
United Dental Care of Michigan, Inc.
United Dental Care of Missouri, Inc.
United Dental Care of Nebraska
United Dental Care of New Mexico, Inc.
United Dental Care of Ohio, Inc.
United Dental Care of Pennsylvannia, Inc.
United Dental Care of Texas, Inc.
United Dental Care of Utah, Inc.
United Dental Ins. Company
Avesis Third Party Admin. Inc.
Best Life and Health Ins Co
Blue Cross Blue Shield of AZ
Blue Cross Blue Shield of MA
Blue Shield of Arkansas
Blue Shield of Hawaii
Blue Cross of Florida
Florida Combined Life Ins Co
USAble Life
Life & Specialty Ventures
Blue Cross Blue Shield of MI
Blue Care Network
Blue Care Network of East MI
Blue Cross Blue Shield of NC
Blue Cross Blue Shield of SC
Blue Shield of CA
CareFirst BlueCross BlueShield
The Dental Network, Inc.
CAREINGTON INTERNATIONAL
The CDI Group
Cigna Dental & Vision Care
Great West Healthcare
Citizens Security Life Ins Co
Companion Life Ins Co
Total Dental Administrators
Dedicated Dental / Interdent
Delta Dental of AZ
Delta Dental of CA, NY, PA & Affiliates
Delta Dental of AK
Delta Dental of AL
Delta Dental of DC
Delta Dental of DE
Delta Dental of GA
Delta Dental of LA
Delta Dental of MD
Delta Dental of MS
Delta Dental of MT
Delta Dental of NV
Delta Dental of TX
Delta Dental of UT
Delta Dental of VT
Delta Dental of WV
Denti-Cal
Delta Dental of IA
Delta Dental of MI, OH, IN
Delta Care
Delta Dental of AR
Delta Dental of TN
Renaissance Dental Network
Renaissance Health Inc. Company of NY
Renaissance Life & Health Ins. Company
Delta Dental of MO
Advantica Benefits
Delta Dental of WA
DENCAP Dental Plans
Dental Care Plus Group Inc.
Dental Health Svcs of America
Custom Benefit Advisors
DBA-Preferred Administrators
Dental Health Svcs (an Oregon corp)
Dental Health Svcs, Inc.
Dental Health Svcs, Inc. (Arizona corp)
Dental Management Svcs
Dental Network Svcs
DHS Ins Svcs Inc

Dental Network of America, Inc. (DNOA)
Blue Cross Blue Shield of IL
Blue Cross Blue Shield of NM
Blue Cross Blue Shield of TX
Colorado Bankers Life
Dearborn National
DenteMax, Inc.
Ft. Dearborn Life Ins Co
Health Care Svcs Corp
Medical Life Ins Co
Dental Select
DentalPlans.com
DentaQuest
Dominion Dental Svcs, Inc
EMI Health
EmblemHealth Svcs
Connecticare
GHI HMO Select
Group Health Inc
GEHA
PPO USA a Division of GEHA
Guardian Life Ins Co of America
Berkshire Life Ins Co of America
First Commonwealth, Inc.
Managed Dental Care
Health Resources, Inc.
HealthPartners, Inc
Central Minnesota Group Health Inc
Group Health Plan Inc
HealthPartners Administrators, Inc.
Midwest Assurance Company
Horizon BCBS NJ
Humana Specialty Benefits
CompBenefits Corporation
Oral Health Svcs
IHC Health Solutions
American National Life Ins. Company
Fidelity Security Life
GroupLink Reins Co LTD
Guarantee Trust Life
Madison National Life Ins Co
Strategic Health Alliance
Kaiser Permanente Dental Care Program
Kansas City Life Ins Co
Liberty Dental Plan
Lifemap Assurance
Lincoln Financial Group
MetLife
SafeGuard Dental and Vision
SafeGuard Health Plans, Inc
SafeGuard Health Enterprises
Mutual of Omaha
National Guardian Life Ins Co
Nevada Dental Benefits
Nippon Life Ins Co of America
Northeast Delta Dental
Pacific Source Health Plans
Pan American Life
Premera Blue Cross
Blue Cross of WA and AK
Lifewise Assurance
Lifewise Health Plan of OR
Premera Blue Cross Blue Shield of AK
Premier Access Dental & Vision
Principal Financial Group
Diversified Dental Svcs
Employers Dental Svcs, Inc.
Reserve National
Risk Solutions Resources
Security Life Ins Co of America
Union Security Life Ins. Company of NY
SelectHealth
Solstice Benefits
Southland National Ins Corporation
Standard Ins Co
Starmount Life Ins Co
Always Care
Sun Life Financial
Superior Dental Care Inc.
TruAssure
United Concordia Companies Inc.
Blue Cross Blue Shield of WV (Mountain St)
Highmark Blue Cross Blue Shield
United Concordia Life & Health
United Healthcare Specialty Benefits
Dental Benefit Providers, Inc.
Illinois Pacific Dental
MAMSI Life & Health Ins Co
National Pacific Dental
Nevada Pacific Dental
Oxford Health Plans
Pacific Union Dental
PacifiCare Dental & Vision
PacificDental Benefits, Inc.
Solstice Benefits
United Health Care Corporation
UPMC Health Plan
WellPoint Dental Svcs
Anthem Blue Cross Blue Shield
Anthem Health & Life Ins Co
Blue Cross Blue Shield of GA
Blue Cross Blue Shield of MO
Blue Cross Blue Shield of WI
Blue Cross of CA
DeCare
Golden West Dental & Vision Plan
Unicare Health Ins Co of the Midwest
Unicare Life and Health Ins Co
Western Dental Svcs

Willamette Dental Insurance, Inc
Willamette Dental Group
Willamette Dental Management Corporation
Willamette Dental of Idaho, Inc.
Willamette Dental of Washington, Inc.
Willamette Dental Group (Skoutes, Inc.)

Associate Members
Aspen Dental
Dental Associates
Dental Care Alliance
DentalOne Partners
Great Expression Dental Centers
Kool Smiles
Heartland Dental Care
Pacific Dental Services
Park Dental
Smile Brands Inc.
West Coast Dental Services

Supporting Organizations
Aldera
BeneCare
Colonial Life & Accident Ins Co
Davis Vision
Dentistat, Inc.& go2dental.com, Inc.
Health Solutions Plus
Healthscape Advisors
McKinsey and Company
Milliman Inc.
P & R Dental Strategies, Inc.
Pacific Resources
Qualbe Marketing
Revolv (formerly Corvesta)
Santech Solutions, Inc.
Secure EDI
Spencer Stuart
Stratose
Tesia Clearinghouse
The Ignition Group
The Premier Dental Group, Inc.
Towers Watson
West Monroe Partners
Wonderbox Technologies

Individual Members
Dr. Peter Barnett
Jeff DeCapua
Dr. D.E. FitzGerald
Lynda Hunnicutt
Dr. Steven Keller
James Kingston
Dr. David Klock, Ph.D.
Dolores Kordek
E. Craig Lesley
Tom Limoli, Jr.
James Lintner
Ray Martin
Timothy Marshall
Allan Morris
David O. Mulligan
Chuck Stewart
Dr. Doyle Williams
Ruth Ann Woodley