NAIC National Association of Insurance Commissioners

Conference Call

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP
Friday, January 22, 2021
12:00 p.m. ET / 11:00 a.m. CT / 10:00 a.m. MT / 9:00 a.m. PT / 8:00 a.m. AT / 6:00 a.m. HT

ROLL CALL

Steve Drutz, Chair	Washington	Rhonda Ahrens/ Michael Muldoon	Nebraska
Steve Ostlund	Alabama		
Eric Unger/Rolf Kaumann	Colorado	Kelsey Barlow	Nevada
Wanchin Chou	Connecticut	Tom Dudek	New York
Carolyn Morgan/Kyle Collins	Florida	Kimberly Rankin	Pennsylvania
Tish Becker	Kansas	Mike Boerner/Aaron Hodges	Texas

NAIC Support Staff: Crystal Brown

AGENDA

1. Receive Comments on the Report of Investment Income in Underwriting Risk from the Academy—*Steve Drutz (WA)* — Attachment A
    a. Follow-Up Letter from Academy—Derek Skoog (American Academy of Actuaries) — Attachment B
    b. Comment Letters
        i. UnitedHealth Group—Jim Braue (UnitedHealth Group) — Attachment C
    c. Underwriting Risk Pages – Health Risk-Based Capital Formula — Attachment D

2. Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*

3. Adjournment

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December 15, 2020

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy)[1] Health Solvency Subcommittee, I am pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide analysis to incorporate investment income into the existing underwriting risk factors within the HRBC formula.

Incorporation of Investment Income into H2 Risk Factors

The H2 risk factors were based on a 5% probability of ruin over a 3- to 5-year period for each line. There is a fair degree of uncertainty with respect to the development of these factors, though it is likely they were developed without consideration of offsetting investment income. To reflect investment income into these factors, we studied the property and casualty (P&C) underwriting risk factor approach, which explicitly includes investment income via an Investment Income Adjustment (IIA).

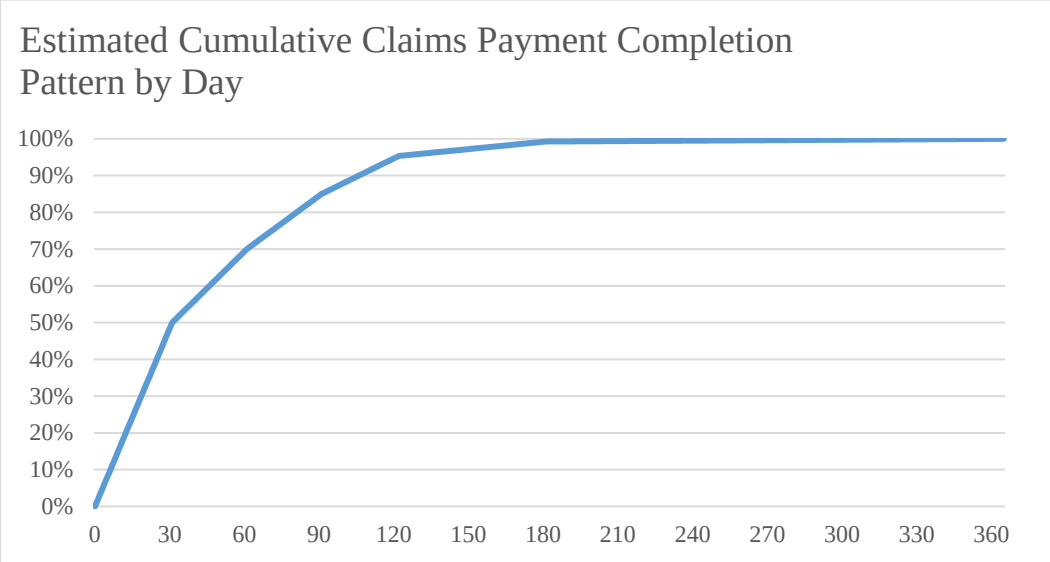
To summarize the P&C framework with respect to the IIA within the P&C Net Written Premium Risk (akin to the Health H2 Experience Fluctuation Risk), the base RBC charge amounts to:

$$Premium * (IIA * Risk\_Factor + Expense\_Ratio - 1)$$

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The IIA*Risk_Factor expression is the discounted loss ratio at the target safety margin (87.5th percentile for P&C). Then, the IIA*Risk_Factor + Expense_Ratio -1 is the discounted operating loss at the target safety margin.

This level of clarity around the components of the risk charges does not exist for the Health risk factors, but, using certain assumptions the P&C framework can be translated into the current Health factors. For example, the base Comprehensive Major Medical risk factor is 9%; if a 9% expense ratio (based on high-level industry benchmarking of health plan administrative expenses, excluding claims adjustment expense) is assumed and no IIA (i.e., an IIA of 1.0), then the underlying Risk Factor is 100%. To estimate the IIA for a typical health product, the subcommittee used the following claims payment completion pattern and assumed that premium is collected at policy onset and investment income is earned on any premium collected less claims paid.



The results are sensitive to the assumed claim payment pattern. For example, if all claims are paid at the end of the year, a full year of investment income could be earned; if all claims were paid immediately, then no investment income could be earned. Under this illustration, the average claim is paid approximately 1.5 months after incurral—largely consistent with health product payment patterns. To the extent actual claims take longer to develop, more investment income will be earned and the Investment Income Adjustment will be larger.

The other key assumption is the investment return. Investment yields based on a high-level analysis of health plan statutory financial statements over the past several years might indicate that a 2-3% assumption would be reasonable, though that may be overstating investment income on written premiums, as approximately half of the claims are paid in about one month and the

one-month Treasury rates are near zero today. Additionally, most investment income is likely earned from surplus funds. Given this uncertainty, the subcommittee performed sensitivity testing to understand the impact returns would have on the Risk Factor, as shown below:

Investment Return	Investment Income Adj.	Risk Charge Adj. Factor	Base Risk Factor
0.0%	1.0000	1.0000	9.00%
0.1%	0.9999	0.9985	8.99%
0.5%	0.9993	0.9927	8.93%
1.0%	0.9987	0.9854	8.87%
1.5%	0.9980	0.9780	8.80%
2.0%	0.9974	0.9707	8.74%
3.0%	0.9960	0.9558	8.60%

One concern raised by the Academy's Solvency Subcommittee is that investment income is not generally a consideration with respect to the underwriting of short-term health care policies. While this is true, the related claims payable reserves and corresponding assets do generate investment returns. Because reserving risk is not considered within the HRBC formula, inclusion of investment income in Experience Fluctuation Risk may be reasonable.

There is considerably more uncertainty around the development of the Health Experience Fluctuation Risk factors than P&C Net Written Premium risk factors, as it has been some time since they were materially changed. As a result, making this change in the RBC formula may be an exercise in false precision because the baseline factors are not well understood. Ultimately, the regulatory usefulness of changes to the RBC formula will depend on both a strong understanding of the starting point and the suggested change. Given the importance of Underwriting Risk factors within the HRBC formula, it may be worth revisiting their development more broadly in the future.

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If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown: Senior Insurance Reporting Analyst

January 11, 2021

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy)[1] Health Solvency Subcommittee, I am pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide additional detail regarding the potential investment income adjustment factor for Health H2 Experience Fluctuation Risk.

Incorporation of Investment Income into H2 Risk Factors

As described in our letter dated December 15, 2020, the property and casualty (P&C) framework with respect to the Investment Income Adjustment (IIA) within the P&C Net Written Premium Risk (akin to the Health H2 Experience Fluctuation Risk), the base RBC charge amounts to:

*Premium * (IIA * Risk_Factor + Expense_Ratio - 1)*

The IIA*Risk_Factor expression is the discounted loss ratio at the target safety margin (87.5th percentile for P&C). Then, the IIA*Risk_Factor + Expense_Ratio -1 is the discounted operating loss at the target safety margin.

For Comprehensive Major Medical, if a 9% expense ratio (based on high-level industry benchmarking of health plan administrative expenses, excluding loss adjustment expense) is assumed and no IIA (i.e., an IIA of 1.0), then the underlying Risk Factor is 100%. This is essentially the loss plus loss adjustment expense ratio at the target safety margin implied by the Health RBC formula.

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The table below summarizes a range of risk factors if an investment income adjustment was applied, assuming a consistent 100% loss and loss adjustment expense ratio and a 9% expense ratio.

Investment Return (a)	Investment Income Adj. (b)	Loss Ratio at safety margin (c)	Expense Ratio (d)	Discounted Risk Factor (b)*(c)+(d)-1
0.0%	1.0000	100%	9%	9.00%
0.1%	0.9999	100%	9%	8.99%
0.5%	0.9993	100%	9%	8.93%
1.0%	0.9987	100%	9%	8.87%
1.5%	0.9980	100%	9%	8.80%
2.0%	0.9974	100%	9%	8.74%
3.0%	0.9960	100%	9%	8.60%

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If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown, Senior Insurance Reporting Analyst

UNITEDHEALTH GROUP

Corporate Finance – Actuarial Services Division
185 Asylum Street, CityPlace I ● Hartford, CT 06103

January 6, 2021

Mr. Steven Drutz, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: American Academy of Actuaries letter regarding an investment income adjustment to Health RBC underwriting risk factors.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group in regard to the December 15, 2020 letter to you from the American Academy of Actuaries (the "Academy"), exposed for comment on December 18, 2020. The letter presented the Academy's analysis of incorporating investment income into the Risk-Based Capital (RBC) charges for health underwriting risk.

We greatly appreciate your Working Group's willingness to address this subject. We hope that our comments on the Academy's letter will assist the Working Group in its further consideration of the matter. We have comments on several distinct aspects of the letter, as shown under separate headings below.

During the Working Group's December 18, 2020 conference call, we requested additional details of the calculations shown in the Academy's letter. We understand that the Academy is preparing to provide those details. As of this writing, we have not yet seen that additional material, and our comments below should be considered in that context. When that material becomes available, we may have additional comments regarding it.

Our support for an adjustment.

It is definitely appropriate for an adjustment to be made. We understand the Academy's remark that, "making this change in the RBC formula may be an exercise in false precision because the baseline factors are not well understood." However, that is not a reason to forgo the adjustment. The current underwriting risk factors are what they are, whether they are well understood or not; they are the baseline we all must work from. The adjustment for investment income should

therefore not be thought of as one element of the development of those factors, which might be offset by other elements that are currently unidentified. Instead, the adjustment should be viewed simply as the introduction of an investment income component into the formula, by means of adjusting the existing underwriting risk factors. Conceptually, the adjustment could be a stand-alone negative component of underwriting risk; the fact that it is instead being added to the existing underwriting risk factors does not somehow invalidate its appropriateness.

Accordingly, we strongly recommend that the Working Group adopt an adjustment to the underwriting risk factors as discussed in the Academy's letter. As we noted at the Working Group's July 30, 2020 virtual meeting, and reiterated in our August 31 comment letter, if for some reason the Working Group does not consider it feasible to implement this adjustment as part of the underwriting risk portion of the RBC formula, then it will be necessary to return to the subject of incorporating investment income into the bond risk factors.

Rate of investment return.

The Academy's letter notes that the amount of the adjustment is highly sensitive to the rate of investment return that is assumed in the calculation. The Academy states that statutory financial results would suggest a rate of 2-3%, but also suggests that the short-term nature of the liabilities (about 1.5 months on average, the letter indicates) might justify a much lower rate.

The run-out period of a single incurral date's claims should not be the determinative consideration, for several reasons. First of all, while the Working Group's deliberations on the bond risk factors are not complete, most recently the Working Group has been contemplating using a 3-year average maturity assumption for that purpose. As we have noted previously, if the risk associated with health entities' bond holdings is to be reflected in the RBC formula, it is important that the corresponding returns likewise be reflected. If (as we had originally recommended) the investment return were being incorporated into the bond risk factors themselves, that linkage would be readily apparent. Merely because the investment returns are instead being incorporated into the underwriting risk factors, that linkage is not somehow broken.

Also, we suggest that the run-out period of a single incurral date's claims is not really relevant from an investment standpoint. As a going concern, a health entity does not repeatedly run its assets down to zero as claims are paid; there is a continual inflow of cash from premiums and other revenues, and investments are held for a longer term (approximating the 3-year average maturity referred to above). Even in a run-out situation, it is unlikely that all payments would run out as quickly as the 1.5-month average cited by the Academy would suggest. We will point out that the Academy, in its August 2018 update on bond risk factors, said, "To estimate the liability runoff duration, we review (a) the duration of unpaid claim liabilities and (b) the duration of claim liabilities and related premium from an additional year of policies." As a result of that review, the Academy selected a 2-year horizon for the bond risk modeling.

In summary, the rate of investment return should be consistent with the time horizon used for the bond risk modeling, whatever that is eventually determined to be. In light of the most recent discussions regarding the bond factors, we would expect that to be either 2 or 3 years.

Another consideration is whether the assumed rate of return should be based on current interest rate levels, or on longer-term averages. This consideration is tied in with the question of how frequently the investment income adjustment should be updated, which we address below.

Scope of application.

During the December 18 call, you raised the question of which Health RBC underwriting risk factors should be subject to the investment income adjustment. Because the pricing and reserving characteristics of long-term disability income and long-term care coverages are so different from those of the majority of the business subject to the Health formula, it makes sense to us that those categories would be excluded. For the other, shorter-tailed lines of business subject to the formula, it seems reasonable to apply the investment income adjustment. Also, where a particular product's underwriting risk factor is tiered by premium volume, the adjustment should be applied to all tiers.

Frequency of updates.

Also during the December 18 call, NAIC staff raised the question of how frequently the investment income adjustment should be updated. As we noted above, we believe that this question is closely related to the question of whether the adjustment should be based on current interest rates or on a longer-term average. If the adjustment is based on current rates, it should be updated whenever market interest rates change significantly. If less frequent updates are desired by the Working Group, then it would be appropriate to use a longer-term average of rates to determine the adjustment.

* * * * *

We appreciate your consideration of these comments. We would be happy to discuss this matter further with the Working Group.

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Crystal Brown, NAIC
Randi Reichel, UnitedHealth Group

UNITEDHEALTH GROUP

Corporate Finance – Actuarial Services Division
185 Asylum Street, CityPlace I ● Hartford, CT 06103

January 13, 2021

Mr. Steven Drutz, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via electronic mail to Crystal Brown.

Re: American Academy of Actuaries letters regarding an investment income adjustment to Health RBC underwriting risk factors.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group, to supplement our January 6, 2021 letter to you regarding the incorporation of investment income into the Risk-Based Capital (RBC) charges for health underwriting risk. As we noted in that letter, the American Academy of Actuaries was expected to provide additional details of the calculations shown in their December 15, 2020 letter, and we stated that we might have further comments when those details became available. The Academy submitted that additional information in a letter dated January 11, 2021. Our comments in response to that letter follow.

The Academy has explained that they have calculated "discounted risk factors" using the following formula:

$$\text{Discounted risk factor} = \text{IIA} * (\text{Loss ratio at safety margin}) + (\text{Expense ratio}) - 1$$

where "IIA" is an Investment Income Adjustment. As we understand it, the IIA represents a discount factor at the indicated rate of investment return, discounted over a period of slightly more than 1.5 months. (Although the exact discounting period is not stated in either of the Academy's letters, from the calculated values it appears that the period is approximately 0.1339 years, or 1.607 months.)

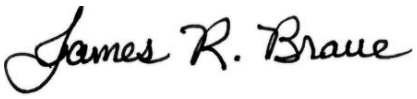
The underwriting risk factors were originally based on modeling over a multiyear period, and from that standpoint it seems that the discounting should occur continuously over that period (or, more approximately, back from the midpoint of the modeling period). However, in that case, the premiums would also have to be discounted, which would result in the constant term in the

above equation being less than 1. The IAA, then, can be interpreted as an approximation of the difference between the impact of discounting on the loss ratio and the impact of discounting on the premium, as the 1.6-month period approximates the difference in timing between the receipt of the premium and the payment of the corresponding claims. Considered in that light, the adjustment seems reasonable.

We will note that, potentially, a similar adjustment should be made to the expense ratio. However, because the expense ratio used by the Academy is so much lower than the loss ratio that they used (9% vs. 100%), there would be much less impact on the final result. Therefore, the lack of an adjustment on the expense ratio could be viewed as providing a small degree of conservatism.

Given the interpretation of the IIA that we've presented above, it is important to note that the 1.6-month discounting period has no relevance to the question of what rate of investment return should be assumed. The 1.6-month discounting period really should be thought of as the difference between two amounts discounted over a longer period. As we explained in our January 6 letter, the assumed rate of investment return should be consistent with investments held for a period of two to three years. The information in this latest letter from the Academy does not alter that position in any way.

We would be happy to discuss these comments with you and the Working Group.



James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Crystal Brown, NAIC
Randi Reichel, UnitedHealth Group

UNDERWRITING RISK

Experience Fluctuation Risk

	Line of Business	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1) †	Premium							
(2) †	Title XVIII-Medicare		XXX	XXX	XXX	XXX	XXX	
(3) †	Title XIX-Medicaid		XXX	XXX	XXX	XXX	XXX	
(4) †	Other Health Risk Revenue		XXX				XXX	
(5)	Medicaid Pass-Through Payments Reported as Premiums		XXX	XXX	XXX	XXX	XXX	
(6)	Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)							
(7) †	Net Incurred Claims						XXX	
(8)	Medicaid Pass-Through Payments Reported as Claims		XXX	XXX	XXX	XXX	XXX	
(9)	Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)						XXX	
(10) †	Fee-For-Service Offset		XXX				XXX	
(11)	Underwriting Risk Incurred Claims = Lines (9) - (10)						XXX	
(12)	Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)						1.000	XXX
(13)	Underwriting Risk Factor*					0.130	0.130	XXX
(14)	Base Underwriting Risk RBC = Lines (6) x (12) x (13)							
(15)	Managed Care Discount Factor						XXX	XXX
(16)	RBC After Managed Care Discount = Lines (14) x (15)						XXX	
(17) †	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(18)	Alternate Risk Charge **						XXX	XXX
(19)	Alternate Risk Adjustment						XXX	XXX
(20)	Net Alternate Risk Charge***						XXX	
(21)	Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)							

TIERED RBC FACTORS*						
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$0 - $3 Million	0.150	0.105	0.120	0.251	0.130	0.130
$3 - $25 Million	0.150	0.067	0.076	0.251	0.130	0.130
Over $25 Million	0.090	0.067	0.076	0.151	0.130	0.130

ALTERNATE RISK CHARGE**

** The Line (15) Alternate Risk Charge is calculated as follows:						
LESSER OF:	$1,500,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$150,000 or 6 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013.

* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Underwriting Risk					
(22)	Business with Rate Guarantees Between 15-36 Months - Direct Premium Earned	Gen Int Part 2 Line 9.21		0.024	
(23)	Business with Rate Guarantees Over 36 Months - Direct Premium Earned	Gen Int Part 2 Line 9.22		0.064	
(24)	FEHBP and TRICARE Claims Incurred	UI, Part 2, Column 6, Line 12.4		0.020	
(25)	Stop Loss and Minimum Premium	Company Records		*	
(25.1)	Supplemental Benefits within Stand-Alone Medicare Part D Coverage (Claims Incurred)	Company Records		0.500	
(25.2)	Medicaid Pass-Through Payments Reported as Premiums	XR012, Column (1), Line (5)		0.020	
(25.3)	Total Other Underwriting Risk	Sum of Lines (22) through (25.2)			
Disability Income Premium					
(26)	Noncancellable Disability Income - Individual Morbidity	Company Records			
(26.1)	First $50 Million Earned Premium of Line (26)			0.350	
(26.2)	Over $50 Million Earned Premium of Line (26)			0.150	
(26.3)	Total Noncancellable Disability Income - Individual Morbidity	Lines (26.1) + (26.2)			
(27)	Other Disability Income - Individual Morbidity	Company Records			
(27.1)	Earned Premium in Line (27) [up to $50 Million less Premium in Line (26.1)]			0.250	
(27.2)	Earned Premium in Line (27) not included in Line (27.1)			0.070	
(27.3)	Total Other Disability Income - Individual Morbidity	Lines (27.1) + (27.2)			
(28)	Disability Income - Credit Monthly Balance Plans	Company Records			
(28.1)	First $50 Million Earned Premium of Line (28)			0.200	
(28.2)	Over $50 Million Earned Premium of Line (28)			0.030	
(28.3)	Total Disability Income - Credit Morbidity	Lines (28.1) + (28.2)			
(29)	Disability Income - Group Long-Term	Company Records			
(29.1)	Earned Premium in Line (29) [up to $50 Million less Premium in Line (28.1)]			0.150	
(29.2)	Earned Premium in Line (29) not included in Line (29.1)			0.030	
(29.3)	Total Disability Income - Group Long-Term	Lines (29.1) + (29.2)			
(30)	Disability Income - Credit Single Premium with Additional Reserves	Company Records			
(30.1)	Additional Reserves for Credit Disability Plans	Company Records			
(30.2)	Additional Reserves for Credit Disability Plans, Prior Year	Company Records			
(30.3)	Sub-Total Disability Income - Credit Single Prem w/Addl Reserves	Lines (30) - (30.1) + (30.2)			
(30.4)	Earned Premium in Line (30.3) [up to $50 Million less Premium in Lines (28.1) + (29.1)]			0.100	
(30.5)	Earned Premium in Line (30.3) not included in Line (30.4)			0.030	
(30.6)	Total Disability Income - Credit Single Premium with Additional Reserves	Lines (30.4) + (30.5)			
(31)	Disability Income - Credit Single Premium without Additional Reserves	Company Records			
(31.1)	Earned Prem in Line (31) [up to $50 Million less Prem in Lines (28.1) + (29.1) + (30.4)]			0.150	
(31.2)	Earned Premium in Line (31) not included in Line (31.1)			0.030	
(31.3)	Total Disability Income - Credit Single Premium without Additional Reserves	Lines (31.1) + (31.2)			
(32)	Disability Income - Group Short-Term	Company Records			
(32.1)	Earned Prem in Line (32) [up to $50 Million less Prem in Lines (28.1) + (29.1) + (30.4) + (31.1)]			0.050	
(32.2)	Earned Premium in Line (32) not included in Line (32.1)			0.030	
(32.3)	Total Disability Income - Group Short-Term	Lines (32.1) + (32.2)			

Denotes items that must be manually entered on filing software.

* A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (25) and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

	Long-Term Care (LTC) Insurance Premium	Annual Statement Source	(1) Amount	Factor		(2) RBC Requirement
(33)	Noncancellable LTC Premium - Rate Risk	Company Records		0.100	*	
(34)	All LTC Premium - Morbidity Risk (to $50 Million)	Line (37.1) Column (1) up to $50 Million		0.100		
(35)	LTC Premium (over $50 Million) - Morbidity Risk	Remainder of Line (37.1) Column (1) over $50 Million		0.030		
(36)	Premium-Based RBC	Column (2), Lines (33) + (34) + (35)				

	Historical Loss Ratio Experience	Annual Statement Source	(1) Premiums	(2) Incurred Claims	(3) Column (2)/(1) Loss Ratio	§	(4) RBC Requirement
(37.1)	Current Year	Company Records					
(37.2)	Immediate Prior Year	Company Records					
(37.3)	Average Loss Ratio	If loss ratios are used, [Column (3), Line (37.1) + Line (37.2)/2, otherwise zero]					
(38)	Adjusted LTC Claims for RBC	If Column (3) Line (37.3) <> 0, then [Column (1), Line (34) + Line (35)] x Column (3), Line (37.3), else Column (2) Line (37.1)					
(38.1)	Claims (to $35 Million) - Morbidity Risk	Lower of Column (2), Line (38) and $35 Million			0.370	†	
(38.2)	Claims (over $35 Million) - Morbidity Risk	Excess of Column (2), Line (38) over $35 Million			0.120	‡	
(39)	LTC Claims Reserves	Company Records			0.050		
(40)	Claims-Based RBC	Column (4), Lines (38.1) + (38.2)					
(41)	LTC RBC	Column (2), Line (36) + Column (4), Lines (39) + (40)					

* The factor applies to all Noncanellable premium.

† If Column (1), Line (37.1) is positive, then a factor of 0.250 is used. Otherwise, a higher factor of 0.370 is used

‡ If Column (1), Line (37.1) is positive, then a factor of 0.080 is used. Otherwise, a higher factor of 0.120 is used

§ If Column (1), Line (37.1) or (37.2) are less than or equal to zero or if Column (2), Line (37.1) or (37.2) are less than zero, the loss ratios are not used and Column (3), Line (37.3) is set to zero.

Denotes items that must be manually entered on filing software.

	Limited Benefit Plans (Individual and Group Combined)	Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
(42)	Hospital Indemnity and Specified Disease	Included in Page 7, Column 9, Line 1 and 2, in part		0.035	
(42.1)	$50,000 if Line (42) is Greater Than Zero				
(42.2)	Total Hospital Indemnity and Specified Disease	Lines (42) + (42.1)			
(43)	Accidental Death & Dismemberment	Included in Page 7, Column 9, Line 1 and 2, in part			
(43.1)	First $10 Million Earned Premium of Line (43)			0.055	
(43.2)	Over $10 Million Earned Premium of Line (43)			0.015	
(43.3)	Maximum Retained Risk for Any Single Claim	Company Records			
(43.4)	Three Times Line (43.3)				
(43.5)	Lesser of Line (43.4) or $300,000				
(43.6)	Total AD&D	Lines (43.1) + (43.2) + (43.5)			
(44)	Other Accident	Included in Page 7, Column 9, Line 1 and 2, in part		0.050	
(45)	Premium Stabilization Reserves	Included in U&I, Part 2D, Column 1, Line 4		-0.500 Φ	
(46)	Total Other Underwriting Risk	Lines (25.3) + (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3) + (41) + (42.2) + (43.6) + (44) + (45)			

Φ This is limited to the Total Net Underwriting RBC on XR012, Column (7), Line (21) Less Column (4), and XR014, Column (2), Lines (25.3), (26.3), (27.3), (28.3), (29.3), (30.6), (31.3), (32.3), XR015 Column (2), Line (36) and XR016 Column (2), Lines (42.2), (43.6), and (44).

Denotes items that must be manually entered on filing software.