NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

NAIC SPRING 2021 NATIONAL MEETING VIRTUAL

Date: 3/4/21

Virtual Meeting
(in lieu of meeting at the 2021 Spring National Meeting)

HEALTH-RISKED BASED CAPITAL (E) WORKING GROUP
Wednesday, March 17, 2021
11:00 a.m. – 12:00 p.m. ET / 10:00 – 11:00 a.m. CT / 9:00 – 10:00 a.m. MT / 8:00 – 9:00 a.m. PT

ROLL CALL

Steve Drutz, Chair	Washington	Rhonda Ahrens/ Michael Muldoon	Nebraska
Steve Ostlund/Jennifer Li	Alabama		
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. Consider Adoption of its Feb. 10, 2021, Jan. 22, 2021, and Dec. 18, 2020, Minutes —*Steve Drutz (WA)* — Attachment A

2. Consider Adoption of the 2021 Health Risk-Based Capital (RBC) Working Agenda —*Steve Drutz (WA)* — Attachment B

3. Receive Comments on Proposal 2021-02-CA (Managed Care Credit-Incentives) —*Steve Drutz (WA)* — Attachment C

4. Discuss Investment Income in Underwriting Risk—*Steve Drutz (WA)*
   a. American Academy of Actuaries (Academy) Letter — Attachment D
   b. Impact Analysis — Attachment E
   c. Frequency of Adjustment
   d. Draft Proposal — Attachment F

5. Discuss Bond Impact Analysis—*Steve Drutz (WA)*

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

7. Adjournment

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Draft: 3/8/21

Health Risk-Based Capital (E) Working Group
Virtual Meeting
February 10, 2021

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 10, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund and Jennifer Li (AL); Rolf Kaumann and Eric Unger (CO); Wanchin Chou, Kathy Belfi and Andrew Greenhalgh (CT); Kyle Collins (FL); Tish Becker (KS); Rhonda Ahrens and Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Matthew Richard, Aaron Hodges, Sean Fulton and Mike Boerner (TX).

1. Discussed Impact Analysis on Investment Income in Underwriting Risk

Mr. Drutz said the Working Group agreed start working on the impact analysis for the investment income adjustment in the underwriting risk factors for Comprehensive Medical, Medicare Supplement, Dental and Vision, and Stand-Alone Medicare Part D lines of business reported on page XR012. He said the Working Group will continue to work with the American Academy of Actuaries (Academy) to review the remaining lines of business once the initial lines of business have been addressed. He said the key assumptions to consider in determining the investment return are asset duration and spread. He noted that the Academy referenced one-month U.S. treasury yields, and these could be used as a reference point; UnitedHealth Group (UHG) suggested that the rate of investment return be consistent with the time horizon used for the bond risk modeling. He asked if the UHG's reference to the rate of investment return was referencing the reference rate to be used, the period over which the return should be calculated, or both. Jim Braue (UHG) said it primarily referenced the reference rate, but it could be both because they are interconnected.

Mr. Drutz said the Working Group will be performing an impact analysis on the bond factors using a two- and five-year time horizon, and one of the key questions that the Working Group will have to address is if the duration between the bonds and investment income in the underwriting risk factors should be linked. Derek Skoog (Academy) said the Academy did not necessarily take a position as far as the duration of the assets, but rather the Academy modeled out a month of premiums and claims for simplicity; however, the investment income would be the same if you were modeling out a full contact year. He said the data point for consideration is the average length of time it took to pay out claims, which was approximately one month. The Academy then referenced the one-month treasury yield, which is fairly low, and that was a consideration for the investment return assumption. Mr. Skoog said the critical assumption is the investment return. How you get to that investment return is going to be the product of the duration of the asset and the risk of the asset that was assumed. Treasury yields would be lower than corporate bonds, which would be somewhat higher. Mr. Skoog said the Academy did not take a position on those two points, but that is what drives the investment return assumption. Mr. Drutz noted that the table in the Academy's letter included the yield assumption and the adjustment that would be based on that yield. He said if the yield were based on a five-year treasury, yielding 0.5% versus a two-year corporate bond that was yielding 0.5%, the adjustments to the risk factors would not change based on the length of the duration of the bonds. Mr. Skoog agreed. Mr. Drutz said that adjustment to the factors is not based on duration.

Mr. Drutz asked the Working Group to consider what rate should be used. He said three-month Treasury yields are at 0.04% and five-year yields are at about 0.46%. He said there appears to be a linear relationship between the yield and the reduction in the risk factor. Mr. Boerner suggested a granular stair step approach using the 0.5%, 1%, 1.5% and 2% returns in the impact analysis. Mr. Dudek agreed with using the four points to show more of the stair step method. Lou Felice (NAIC) said the investment returns appear to be the outer markers, and the 0% is essentially a one-month Treasury yield up to something like a two- to three-year investment grade corporate bond. He asked if the 2–3% investment return is about where a two- to three-year corporate return is today. Edward Toy (Risk & Regulatory Consulting LLC) said corporate "A" rated yields are about 1.66%, and "BBB" corporates are just over 2%.

Mr. Drutz said the Working Group will also need to consider if there is a certain reference rate when making the assumptions on the investment yields. For example, should the Working Group look at "A" rated corporate bond yields over five- or two-year periods or should it be treasuries or a mix of both. Mr. Drutz said the Working Group will also need to consider the frequency of the adjustment, and he suggested setting a benchmark to determine what assumptions to use. He said as an example, if the adjustment was based on a corporate five-year yield, the Working Group could then review that number annually and adjust the risk charge based on whether that return is going up or down. He said if the benchmark linked to a particular rate of return, it would be helpful in making decisions on the adjustment to the factors in the coming years.

The Working Group agreed to run the impact analysis on a half point basis from 0.5% up to 2%.

2. Exposed Proposal 2021-02-CA

Mr. Drutz said NAIC staff drafted proposal 2021-02-CA, which clarifies and includes a reference for "incentives" where "withholds and bonuses" are referenced in the Managed Care Credit instructions. A definition was also included in Appendix 1 for "Incentives, Bonuses and Withholds." Mr. Drutz said the following questions need to be considered: 1) whether there is a consistent use of incentives, where a set amount is paid; and 2) whether there are scenarios in which incentives could be classified or the payment is built into the claim payment. Mr. Felice said NAIC staff received a question related to what gets included in some of the managed care credit lines calculation for category 2. He said the question was focused on the line in that category, which says to report net of withholds; in other words, this means the full amount of the claim before adjustment for the withhold and also net of bonuses, which means that if there is a bonus that was paid out, it would show the amount of the claims that were paid without including the bonus. He asked what to do with incentives. In the past, incentives were normally paid out after the actual claim was paid, it would be included like a bonus or withhold, and the value of the claim would be reported without consideration of those items on that line. However, there are some items, mostly in government programs, that are called incentives where the incentive is built into the value of the claim. The claim is then paid at an increased value to encourage things like getting a doctor to participate in an underserved area or to help a doctor with the International Classification of Diseases (ICD) 10 in a small office to upgrade their abilities to share or report claims data and medical information. In most cases, these would be reported like a bonus and withhold arrangements because they were called incentive pools—pools of money set aside to, not dissimilar to a bonus arrangement and paid after the claim. However, if there are instances where the claim is enhanced and that is considered an incentive arrangement, we want to be sure that we instruct this to be reported properly. Mr. Felice asked industry users who see these arrangements every day whether there are arrangements with no distinction between the claim value and the incentive because it is paid under a contractual arrangement.

Hearing no objections, proposal 2021-02-CA was exposed for a 30-day public comment period ending March 12. Following the initial exposure, the proposal will then be referred to the Capital Adequacy (E) Task Force for a subsequent exposure for all lines of business.

3. Discuss Bond Factor Analysis

Mr. Drutz said the Working Group agreed to perform an impact analysis on the two- and five-year time horizon factors for the 20 bond designations for year-end 2020; and while a majority of states have a March 1 annual statement filing deadline, there are a few states that have a March 31 or April 1 filing deadline. He recommended that the companies with a March 1 filing deadline be included in the impact analysis to ensure that the April 30 exposure deadline can be met. Mr. Ostlund asked how many companies do not have the March 1 filing deadline. Crystal Brown (NAIC) said she would identify the states with the March 31 and April 1 filing dates and the number of companies that would not file until that date, and she will bring this information back to the Working Group.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

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Draft: 3/8/21

Health Risk-Based Capital (E) Working Group
Virtual Meeting
January 22, 2021

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Jan. 22, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund (AL); Eric Unger (CO); Wanchin Chou and Andrew Greenhalgh (CT); Kyle Collins (FL); Tish Becker (KS); Lindsay Crawford and Michael Muldoon (NE); Kelsey Barlow (NV); Tom Dudek (NY); Kimberly Rankin (PA); and Matthew Richard, Aaron Hodges and Mike Boerner (TX).

1. Discussed the Academy's Report on Investment Income in Underwriting Risk

Mr. Drutz said the American Academy of Actuaries (Academy) report that was exposed in December 2020 discussed the incorporation of investment income into the underwriting risk component and that additional information was requested regarding the proposed adjustment for investment income. Derek Skoog (Academy) summarized the Academy's response (Attachment) and said that the investment income adjustment to the underwriting factors was similar to how it is contemplated in the property/casualty (P/C) formula. He said that the Academy analyzed the comprehensive medical factors that are currently in the underwriting risk component of the health formula and assumed there was not an investment income adjustment included in the current factors. The Academy developed a set of underlying factors that would correspond to the P/C formula and then developed an investment income adjustment based on investment income that is earned on premium collected less claims paid. This considers the development and payment pattern of claims for a typical major medical policy. Then using that investment income assumption, the Academy applied that to the risk factors to develop an alternative set of experience volatility risk factors within each of the tiered factors. Mr. Skoog said that the follow-up letter laid out more detail for the arithmetic for how the investment income adjustment factor gets applied within the P/C construct and shows how the output or the resulting risk factors would result from that approach.

Mr. Chou asked if the Academy was able to look at the P/C on page PR017 for the adjustment of investment income as a factor by line for consistency between the formulas. Mr. Skoog said that served as a basis for the Academy's analysis and said that exact approach was taken. However, rather than expanding the reporting structure in H2 of the health formula for experience volatility risk, the Academy was able to get a similar result by using industry factors. He said that the Academy opted for a simpler and higher-level approach in which the same logic was used. Mr. Chou asked if the 87.5% confidence level was used. Mr. Skoog said no. He said the original request was to consider investment income without adjusting other components of the formula. He said that if the 9% risk factor within the health risk-based capital (RBC) formula were decomposed into the P/C construct, it would basically imply an administrative expense ratio of about 9%. He said there was no investment income adjustment within the current construct, and that would imply a safety or confidence level of about a 100% loss ratio. Mr. Skoog said this would be the corresponding loss ratio in the P/C formula if the same construct was used. He said the Academy did not change those assumptions as this would have led to a more significant study of loss ratios and safety levels that would require more significant changes to the H2 component. He said that the Academy simply applied an investment income adjustment to the factors as they are currently constructed using the P/C construct.

Mr. Drutz said the letter indicated that a 0.5% return would have about a 0.07 percentage point decrease in the 9% factor for comprehensive medical. He asked if this same percentage decrease could be applied to the other tiers and lines of business on page XR012. Mr. Skoog said a similar approach could be applied to the other lines of business by looking at particular claim's payment patterns for those lines to the extent that they may differ from comprehensive major medical. For example, Medicare Supplement paid claims are substantially slower than comprehensive major medical, so it may merit a different adjustment. However, in terms of magnitude, the adjustments would be very similar to that of the comprehensive major medical.

Jim Braue (UnitedHealth Group—UHG) summarized the UHG's comment letter (Attachment). He said that UHG supports making an adjustment for investment income in the formula. He said that the Academy letter noted that the amount of the adjustment is highly sensitive to the rate of investment return that is assumed, and it was also noted that statutory financial results would suggest a rate of 2% to 3%, but an amount lower may be justified by the short-term nature of the liabilities. He said that UHG believes that something consistent with a slightly longer maturity such as two to three years is more appropriate. Mr. Braue said since there is a charge applied for the risk of the bond, there should be some recognition for the income and revenue produced by those bonds. Therefore, it seems appropriate to have the revenue assumption sync up with risk assumption for the bond factors. He said the run-out period of the liabilities are not reflected in the underwriting risk factors. If it were, it would be a reserve risk and not an underwriting risk, and the risk being looked at here is the risk for future incurred claims

being higher than future payments. He asked if current interest rates or longer-term averages should be used, as this ties into the frequency of updating the factors. If current rates are used, it implies that every time the current rate changes appreciably, the factors would need to be adjusted. If the factors were to be updated less frequently, a longer-term average rate would be more appropriate. Mr. Braue said that it is probably not appropriate to apply the adjustment to the factors for long-term disability and long-term care insurance (LTC) due to the nature of those coverages and because there is a risk charge applied to the claim reserves. However, an adjustment could be considered for those shorter-tailed coverages that behave like comprehensive medical and where the risk charges are determined in a similar fashion. He said where there are tiered factors, both tiers should be adjusted.

Mr. Drutz said there are several decision points that the Working Group will need to address prior to implementation of a factor adjustment: 1) whether the issue of bond default risk and investment revenue should be based on the same duration of assumptions; 2) the appropriate duration for applying the underwriting credit; and 3) the appropriate interest rate of return to be used in adjusting the underwriting factor.

Lou Felice (NAIC) said that from a health perspective and based on the Academy's review, the duration of the asset holding is longer, which seems to be an appropriate measure in determining default risk because the length of time that the bond is held is related to whether there is a potential for default over that time. However, the crediting of investment income could use a one-year underwriting cycle due to the short duration of claims. He said that a one-year underwriting cycle could be a little longer as the run out is longer. However, given the short run out, given that premium changes are usually limited to once a year, and given that product design and selection changes once a year, a one-year time period could be used as an under-investment risk duration. He said that for health specifically, bond default risk and investment return risk are not as well connected as they are for P/C, so different durations could be considered for default risk on bonds versus underwriting risk benefit from investment income. Mr. Felice said that the frequency of review is tied to the rate selected, so if a smaller return percentage is used, then the factors would need to be reviewed more frequently and a larger return percentage could be reviewed less frequently. He said if a risk-free or pegged rate were used, the factors would need to be reviewed very frequently. However, if portfolio rates were used, they would need to be reviewed less frequently. There are two items to consider with portfolio rates: 1) whether perverse incentives are created to get more credit by investing in risky assets to raise their portfolio rates of return; and 2) changes to the bond factors or asset risk factors may not have as robust of change as changes to the underwriting risk factors in the formula. Therefore, a small change to the underwriting risk factors may have more of an impact on RBC after covariance than a larger change to a bond factor or asset factor.

Mr. Drutz said that if there is no structural change, the factor updates could be relatively simple. He said there are a couple of methods that could be considered for updating: 1) if a five-year duration were used, the adjustment could be tied to a five-year Treasury bond or some other bond that was published, which could then be used to adjust the factors on an annual basis; or 2) it could be tied to the average investment income of companies. Mr. Drutz suggested that the Working Group run an analysis on the 2019 health RBC data to determine the impact of incorporating the investment income adjustment in the underwriting risk factors and the impact that it would have on RBC ratios. Mr. Muldoon agreed that an impact analysis was a good idea to see what kind of impacts these changes would have.

Mr. Muldoon also asked what lines of business on page XR012 would be considered under the adjusted factors. Crystal Brown (NAIC) asked if the Academy would be able to provide the Working Group with adjusted factors for each line of business in which the investment income would be incorporated into. Mr. Skoog said that the Academy could provide updated factors by line of business, but it would be easier to isolate the lines of business that the adjustment should be applied to because premium collection relative to claims payout patterns would need to be considered.

Mr. Drutz said that the Working Group would like to come to a conclusion on both the bond factors and investment income adjustment projects at the same time and implement for year-end 2021 if possible. Therefore, the Working Group will need to look at the materiality and impact of the investment income adjustment and determine which lines of business the adjustment would apply to. Ms. Brown asked how long it would take the Academy to provide factors for the additional lines of business. Mr. Skoog said that some lines of business will be more challenging than others to get a good view of claim payment patterns. He said that comprehensive medical, Medicare Supplement, dental and vision, and stand-alone Medicare Part D coverage are the most straightforward lines of business, while other health and other non-health may be more challenging because of the number of products that fall under these categories. He said page XR012 would be the most straightforward page and said that the Academy could provide updated factors to the Working Group within a few weeks. Mr. Felice asked if it was necessary to incorporate the investment income adjustment across all the lines of business this year or could the most straightforward lines of business include the adjustment this year and then continue working on the other lines of business. Mr. Felice also asked for clarification on including the adjustment across the tiers and what the Academy thinks about this. Mr. Skoog said that it was

not originally included but that it should apply to all tiers. He said the Academy could provide this. Mr. Braue said that the majority of business is going to be included in Columns 1–4 on page XR012. He suggested that the Academy work on providing adjusted factors for just those four lines of business for year-end 2021 and then over the longer term look at the other lines of business that are more difficult to analyze to determine if any of them are material enough to make any difference. Mr. Skoog said that the Columns 1–4 lines of business are the most straightforward and that the Academy could work on those for this year.

The Working Group agreed and requested that the Academy look at the lines of business in Columns 1–4 on page XR012 and provide an updated analysis like the comprehensive medical and incorporate the tier breakdowns.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

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Draft: 1/29/21

Health Risk-Based Capital (E) Working Group
Virtual Meeting
December 18, 2020

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Dec. 18, 2020. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund (AL); Eric Unger (CO); Wanchin Chou and Andrew Greenhalgh (CT); Kyle Collins (FL); Brenda Johnson and Chut Tee (KS); Rhonda Ahrens and Michael Muldoon (NE); Kelsey Barlow (NV); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges and Mike Boerner (TX).

1. Referred the Health Care Receivable Proposal to the Blanks (E) Working Group

Mr. Drutz said the health care receivable proposal provides additional clarification on the annual statement instructions as a result of feedback in the drafting of the health care receivable guidance. The recommended changes include: 1) adding a reference to "Other Health Care Receivables" in Line 24 of the Assets page; 2) adding "Health Care" to the "Other Receivables" line on Exhibit 3 for consistency across the schedules and risk-based capital (RBC); and 3) modifying the headers of Exhibit 3A to provide additional clarification. No comments were received during the 30-day public comment period.

Mr. Boerner made a motion, seconded by Mr. Dudek, to refer the Health Care Receivable Proposal to the Blanks (E) Working Group for consideration in 2021 reporting (Attachment __). The motion passed unanimously.

2. Exposed the Academy's Report on Investment Income in Underwriting Risk

Mr. Drutz said the incorporation of investment income into the health RBC formula was brought forward by industry participants through the bond factor discussion. Including investment income within the bond factors would require several considerations; therefore, the Working Group agreed to instead look at incorporating investment income into the Underwriting Risk component. The Working Group asked the American Academy of Actuaries (Academy) to review and analyze incorporating investment income into Underwriting Risk component of the health RBC formula.

Derek Skoog (Academy) said the Academy studied the background of the underwriting risk factors, and given their age, the task was somewhat challenging. The Academy was able to refer to an old Academy report, and it found that the calibration of the factors was different than the property and casualty formula; however, it was still able to decompose the factors into a construct similar to the property and casualty formula for the purposes of the investment income adjustment. Mr. Skoog said the Academy went through that exercise with the major medical base risk charge of 9% in a range of investment income return assumptions. He said depending on the investment return, the underwriting risk factor could go from 9% to 8.6% with an investment return of 3% and then graded between the 8.6% and 9% for lower investment returns.

Mr. Skoog said one of the challenges is determining what the investment return should be due to sensitivity. He said given the low interest rate environment—something between 0–1% range—may make the most sense; but ultimately, that is a decision of the Working Group. He said the other item tested was the speed of which claims are completed, because you are essentially earning investment income under this approach based on whatever residual premium you have after you have paid claims. To the extent that it takes longer to pay claims, you get more of an investment income benefit. Mr. Skoog said the Academy used a normal working claims completion rate so that the results are not overly sensitive to that as they are to the actual investment return. However, there is still some sensitivity; therefore, a range of outcomes was presented. Mr. Skoog said one of the fundamental challenges is in the underlying factors themselves because the base risk charges that are presented within the health RBC formula are a bit dated and do not necessarily tie to quantitative results as they do in the property and casualty formula, which can make any analysis somewhat challenging.

Jim Braue (UnitedHealth Group—UHG) asked if the investment return assumption was the 2–3% return on invested assets. Mr. Skoog said that was correct; it was from the statutory schedules by looking at the return on invested assets relative to invested assets on the balance sheet. Mr. Braue said one month treasury rates may not be relevant to this discussion because for the purposes of the bond factors, the Working Group is looking at a two- to three-year maturity range. He said it would seem appropriate that if the regulated legal entity is being charged for the risk of those longer investments, then it should likewise receive the benefit of those longer investments. Therefore, the return assumption should be consistent with the maturity assumption used for the bond factors to maintain consistency of the risk and return throughout the formula.

Mr. Braue asked for further clarification on how to get from Column 1 to Column 2 and then to Column 3 on the Risk Factor table within the report. He suggested that an example would be helpful to follow the development. He said there was a note in the final paragraph that making a change to the formula could be an exercise in false precision. He said there is a lot of rounding in the existing underwriting risk factors, and had this been incorporated into the original factors, that rounding may have eliminated this effect anyway; but what we have today is a 9% factor, so we should not necessarily be concerned about whether the net of the 9% and this adjustment has a reasonable degree of precision but instead think about whether the adjustments to the 9% factor are appropriate.

Mr. Skoog said the Academy could provide an update on the formulas and description used to move from Columns 1 through 3 on the Risk Factor table. Mr. Chou asked how the 87.5th percentile translated into the adjusted factor. Mr. Skoog said this is how property and casualty developed the risk factor. He said it is essentially the loss ratio at that level of confidence. He said health does not have that same level of construct, but if you were to reconstruct the health risk factor the same as property and casualty risk factors were constructed, it would imply that the risk factor was about a 100% loss ratio. However, because the factor is dated and the Academy does not have the work papers on how it was built, it would be the implied health loss ratio at that same confidence level. Mr. Chou asked if the loss ratio would be at 100% if the confidence level was at the 87.5th percentile. Mr. Skoog agreed and said if you assume that today the health formula does not have an investment income adjustment, and we assume that an expense ratio for a typical health plan is about 9%, excluding claims adjustment expenses, the implied loss ratio at that confidence level is 100%.

Mr. Ostlund said duration is considered in determining the appropriate rate. He said there are times when RBC has looked at long durations for longer duration bonds; however, in this instance, we have a claim payment on major medical claims that have a very short duration, and the Academy appropriately chose the short duration and interest rate to use. He said he agrees with the Academy's recommendation to use a short duration rather than a longer duration.

Mr. Drutz asked if an investment return of 1% was used, would the factors be reduced by 0.13 percentage point across all tiers and lines of business. Mr. Skoog said you could essentially use the 1% as a scaler for other similar lines of business, so it would then be the 0.9854 factor. Mr. Drutz asked if there was a contemplation about applying the adjustment to only the Experience Fluctuation Risk page or whether it would be applied to other lines, such as federal employee health benefits or disability lines. Mr. Skoog said the Academy did think about this; the same logic holds across the lines within your experience fluctuation risk, and a similar scaler makes sense. However, the one thing to be mindful of is that there is some sensitivity to claim payment pattern, so a proposed scaler may not appropriate for something that does not look like comprehensive major medical when looking at the longer tailed items. Mr. Skoog said a higher investment income adjustment may need to be considered, but the Academy would need to look at the claims payments for each of those lines of business. Lou Felice (NAIC) asked if it is more likely that the factors would have to be updated more frequently if a shorter duration is used since you would need to be more conservative and adhere closer to a treasury note, whereas with a longer duration you could maybe be less conservative in anticipation of loosening over time. He also asked if the report discussed how frequently the factors would need to be adjusted. Mr. Skoog said the Academy did not consider the frequency for updating; however, in the prevailing interest rate environment, it is the most impactful reason to adjust going forward, to the extent that the interest rate environment moves past the near zero amount. He agreed that it is something worth looking at.

Hearing no objections, the Working Group agreed to expose the Academy's report to include Investment Income in the Underwriting Risk with the additional follow-up and clarification on Columns 1 through 3 on the Risk Factor table (Attachment) for a 30-day public comment period ending Jan. 18, 2021.

3. Received a Summary of Blanks Proposals and Discussed Next Steps for the Health Test Ad Hoc Group

Mary Caswell (NAIC) provided a summary of proposals 2020-32BWG, 2020-33BWG and 2020-38BWG for the Working Group. She said proposal 2020-32BWG adds Exhibits 3 and 3A as supplements to the life blank to allow for the data capture of health care receivable information. She said the Blanks (E) Working Group also approved the posting of the health care receivable guidance that the Working Group previously referred to them, and a link to this guidance was also incorporated into the instructions of this proposal. She said proposal 2020-33BWG is a change to the references used for the health annual statement lines used within the property and casualty annual statement blank to be more consistent with the terms used in the health blank. She said the purpose of proposal 2020-38BWG is to modify the Accident and Health Policy Experience Exhibit to provide state insurance regulators additional health data and greater consistency across the blanks.

Mr. Drutz said the Health Test Ad Hoc Group had taken a pause in meeting during the development of the Blanks proposals, and he suggested that the group resume meeting to determine if they would like to provide comments on the proposals and later discuss the health test language.

4. Discussed Other Matters

Mr. Drutz said the Excessive Growth Ad Hoc Group will meet Jan. 8 and begin reviewing the data for the analysis.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

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Priority 1 – High priority
Priority 2 – Medium priority
Priority 3 – Low priority

CAPITAL ADEQUACY (E) TASK FORCE
WORKING AGENDA ITEMS FOR CALENDAR YEAR 2020

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
				Ongoing Items – Health RBC			
13	Health RBC WG	3 ~~1~~	Year-end 202~~221~~ RBC or later ~~2021 Spring Meeting~~	Evaluate the impact of Federal Health Care Law on the Health RBC Formulas	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula as a result of ongoing federal discussions and legislation. ~~Consider and refer proposal~~ **Adopted proposal** 2020-02-CA ~~to the TF for the deletion of the ACA Fee Sensitivity Test.~~	~~07/30/2020~~
14	Health RBC WG	3	Year-end 202~~221~~ RBC or later	Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales	HRBCWG	Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
				Carry-Over Items Currently being Addressed – Health RBC			
15	Health RBC WG	3	Year-End 2023 RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA	
16	Health RBC WG	2	Year-end 2023 RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H **Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to Blanks (E) Working Group**	

Priority 1 – High priority
Priority 2 – Medium priority
Priority 3 – Low priority

CAPITAL ADEQUACY (E) TASK FORCE
WORKING AGENDA ITEMS FOR CALENDAR YEAR 2020

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
17	Health RBC WG	1	Year-end 2022 or later	Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks	HRBCWG	Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks.	8/4/2018
18	Health RBC WG	1	Year-end 20~~22~~**23** RBC or later	Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. **Review Managed Care Credit across formulas.**	HRBCWG	Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 & 1 to 2a and 2b.	12/3/2018
19	Health RBC WG	1	Year-end 20~~22~~**23** or later	Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
~~20~~	~~Health RBC WG~~	~~1~~	~~2021 Spring Meeting~~	~~Review and consider the formula for the MAX function in Line 17 of the Excessive Growth Charge.~~	~~HRBCWG~~	~~**Adopted** 2020-04-H~~	~~4/3/2020~~
21	Health RBC WG	1	Year-End 20~~22~~**23** or later	Consider impact of COVID-19 and pandemic risk in the Health RBC formula.	HRBCWG		7/30/2020
22	**Health RBC WG**	**1**	**Year-End 2021 or later**	**Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula.**	**HRBCWG**	**Referral Letter was sent to the Academy on Sept 21. Proposal 2021-04-CA**	**8/18/2020**
23	**Health RBC WG**	**1**	**2021**	**Discuss and determine the bond factors for the 20 designations.**	**Referral from Investment RBC July/2020**	**Working Group will use two- and five-year time horizon factors in 2020 impact analysis.**	**9/11/2020**
				New Items – Health RBC			

Capital Adequacy (E) Task Force

RBC Proposal Form

[x] Capital Adequacy (E) Task Force
[ ] Catastrophe Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup
[ ] Health RBC (E) Working Group
[ ] Investment RBC (E) Working Group
[ ] P/C RBC (E) Working Group
[ ] Life RBC (E) Working Group
[ ] Longevity Risk (A/E) Subgroup

DATE:	**1-28-21**
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ON BEHALF OF:	**Health RBC (E) Working Group**
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TITLE:	**Chief Financial Analyst/Chair**
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ADDRESS:	**PO Box 40255**
	Olympia, WA 98504-0255

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Agenda Item # 2021-02-CA

Year 2021

DISPOSITION

[ ] ADOPTED _____
[ ] REJECTED _____
[ ] DEFERRED TO _____
[ ] REFERRED TO OTHER NAIC GROUP
[ ] EXPOSED _____
[ ] OTHER (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[x] Health RBC Blanks
[x] Health RBC Instructions
[x] Property/Casualty RBC Blanks
[x] Property/Casualty RBC Instructions
[x] Life and Fraternal RBC Instructions
[x] Life and Fraternal RBC Blanks
[ ] OTHER _____

DESCRIPTION OF CHANGE(S)

Incorporate references for “Incentives” under the managed care instructions and blank as “Bonuses/Incentives.”

REASON OR JUSTIFICATION FOR CHANGE **

Currently the managed care instructions and blank only reference the bonuses, this change would clarify that both incentives and bonuses are to be included.

Additional Staff Comments:

**** This section must be completed on all forms.** **Revised 2-2019**

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UNDERWRITING RISK – MANAGED CARE CREDIT
XR017

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase, or new arrangements may be added to the existing categories. The managed care categories are:

* Category 0 – Arrangements not Included in Other Categories
* Category 1 – Contractual Fee Payments
* Category 2 – Bonus and/or Incentives / Withhold Arrangements
* Category 3 – Capitation
* Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year's paid claims.

Line (1) – Category 0 – Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted FFS (based upon charges).
- Usual Customary and Reasonable (UCR) Schedules.
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Stop-loss payments by a health entity to its providers that are capitated or subject to withhold/incentive programs.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).

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This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (2) – Category 1 – Payments Made According to Contractual Arrangements**.** There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, DRGs or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- RVS where the payment base and RV factor are fixed by contract for more than one year.
- Ambulatory payment classifications (APCs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (3) - Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives With No Other Managed Care Arrangements**.** This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE – **2019** Reporting Year

2018 withhold / bonus/incentive payments	750,000
2018 withholds / bonuses/incentives available	1,000,000
A. MCC Factor Multiplier	75% – Eligible for credit
2018 withholds / bonuses/incentives available	1,000,000
2018 claims subject to withhold - gross*	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claim payments subject to withhold - net** in the current year.

*** These are amounts due before deducting withhold or paying bonuses and/or incentives.**
**** These are actual payments made after deducting withhold or paying bonuses and/or incentives.**

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements. This amount should equal Exhibit 7, Part 1, Column 1, Line 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claim payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (5) – Category 3a – Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (6) – Category 3b – Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries. An *intermediary* is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health entity and its enrollees via a separate contract between the intermediary and the health entity. This includes affiliates of a health entity that are not subject to RBC, except in those cases where the health entity qualifies for a higher managed care credit because the capitated affiliate employs providers and pays them non-contingent salaries, and where the affiliated intermediary has a contract only with the affiliated health entity. A *Regulated Intermediary* is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state.

Line (7) – Category 3c – Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0.)

Enter the amount of medical expense capitations paid to non-regulated intermediaries.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions

either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

Line (8) – Category 4 – Medical & Hospital Expense Paid as Salary to Providers**.** There is a managed care credit of 75 percent for claim payments in this category. Once claim payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on line 7 in the Underwriting Risk section should be deducted before applying the managed care credit factor. This category includes:

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities, which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with its affiliated health entity.
- All facilities related medical expenses and other non-provider medical costs generated within a health facility that is owned and operated by the health entity.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as "medical expense" payments (paid claims) rather than administrative expenses. The "aggregate cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

This amount should equal Exhibit 7, Part 1, Column 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (9) – Sub-Total Paid Claims. The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental [should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement and the sum of Lines (8.3), (12) and (13) on page XR017 – Underwriting Risk – Managed Care Credit.

Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection**.** Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection**.** Category 1 for Medicare Part D Coverage would be all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection**.** Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection**.** Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (14) – Sub-Total Paid Claims**.** The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

Line (16) – Weighted Average Managed Care Discount. These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4) Line (14) divided by Column (2), Line (14).

Line (17) – Weighted Average Managed Care Risk Adjustment Factor**.** These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor. These do not apply to Medicare Part D coverage.

Line (18) – Withhold & Bonus/Incentive Payments**, *prior year*.** Enter the prior year's actual withhold and bonus/incentive payments.

Line (19) –Withhold & Bonuses/Incentives Available**, *prior year*.** Enter the prior ~~year's~~years withholds and bonuses/incentives that were available for payment in the prior year.

Line (20) – MCC Multiplier – Average Withhold Returned**.** Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21) – Withholds & Bonuses/Incentives Available, ***prior year*.** Equal to Line (19) and is automatically pulled forward.

Line (22) – Claims Payments Subject to Withhold, ***prior year*.** Claim payments that were subject to withholds and bonuses/incentives in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) – Average Withhold Rate, ***prior year*.** Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) – MCC Discount Factor, Category 2**.** Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health ~~entity's~~entities withhold/bonus/incentive program in the prior year.

LIFE

UNDERWRITING RISK - MANAGED CARE CREDIT

LR022

This worksheet LR022 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the comprehensive medical dental business, Stand-Alone Medicare Part D Coverage or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 - Arrangements not Included in Other Categories
- Category 1 - Contractual Fee Payments
- Category 2 – Bonus and/or incentives / Withhold Arrangements
- Category 3 - Capitation
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year's paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to insure that true risk transfer is accomplished.

Line (1)

Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted fee for service (based upon charges).

- Usual customary and reasonable (UCR) schedules.
- Relative value scale (RVS), where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
- Claim payments not included in other categories.

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Line (2)

Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- Relative value scale (RVS), where the payment base and RV factor are fixed by contract for more than one year.

Line (3)

Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE - 1998 Reporting Year	
1997 withhold / bonus/incentive payments	750,000
1997 withholds / bonuses/incentives available	1,000,000
A . MCC Factor Multiplier	75% - Eligible for credit
1997 withholds / bonuses/incentives available	1,000,000
1997 claims subject to withhold -gross†	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.

‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

Line (4)

Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments to regulated intermediaries that, in turn, pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 2 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitated or percent of premium payments to non-affiliated intermediaries that, in turn, pay licensed providers (subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations that meet the definition in Appendix 2 for Intermediary but not regulated intermediary. In those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater

of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions either within or beyond a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for both providers and intermediaries.

Line (8)
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
- All facilities-related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as "medical expense" payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

Line (9)
Subtotal Paid Claims – The total of Column (2) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line A.4 of the annual statement.

Line (10)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11)
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (16)
Weighted Average Managed Care Discount – The amounts in Column (3) and Column (4) are calculated by dividing the total weighted claims in Column (3) by the total claims paid in Column (2) for Lines (9) and (14) respectively.

Line (17)

Weighted Average Managed Care Risk Adjustment Factor – These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (16)).

Lines (18) through (24)
Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (18)
Enter the prior year's actual withhold and bonus/incentive payments.

Line (19)
Enter the prior year's withholds and bonuses/incentives that were available for payment in the prior year.

Line (20)
Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21)
Equal to Line (19) and is automatically pulled forward.

Line (22)
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of LR022 Underwriting Risk – Managed Care Credit FOR THE PRIOR YEAR.

Line (23)
Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24)
Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer's withhold/bonus/incentive program in the prior year.

PR021 - Underwriting Risk – Managed Care Credit

This worksheet PR021 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical, Stand-Alone Medicare Part D Coverage, Dental business or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

* Category 0 - Arrangements not Included in Other Categories
* Category 1 - Contractual Fee Payments
* Category 2 – Bonus and/or Incentives / Withhold Arrangements
* Category 3 - Capitation
* Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10.1) through (10.4) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year's paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to ensure that true risk transfer is accomplished.

Line (1)

Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

* Fee for service (charges).
* Discounted fee for service (based upon charges).
* Usual customary and reasonable (UCR) schedules.
* Relative value scale (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.

* Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
* Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
* Claim payments not included in other categories.

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Line (2)

Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

* Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
* Non-adjustable professional case and global rates.
* Provider fee schedules.
* Relative value scale (RVS) where the payment base and RV factor are fixed by contract for more than one year.

Line (3)

Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE - 1998 Reporting Year	
1997 withhold / bonus payments	$750,000
1997 withholds / bonuses available	$1,000,000
A. MCC Factor Multiplier	75% - Eligible for credit
1997 withholds / bonuses available	$1,000,000
1997 claims subject to withhold -gross†	$5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.

‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

Line (4)

Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a provider fee schedule

(Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments made directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments to regulated intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 1 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitated or percent of premium payments to non-affiliated intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition of Intermediary but not regulated intermediary in Appendix 1. In cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive

revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for providers and intermediaries.

Line (8)
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

* Non-contingent salaries to persons directly providing care.
* The portion of payments to affiliated entities which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
* All facilities related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
* Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as "medical expense" payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, that put their respective capital and surplus at risk in guaranteeing each other.

Line (10.1)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (10.2)
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (10.3)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (10.4)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (10.6)
Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line D16 of the annual statement.

Line (11)
Weighted Average Managed Care Discount – This amount is calculated by dividing the total weighted claims (Line (9) Column (2)) by the total claim payments (Line (9) Column (1).

Line (12)

Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (11)).

Lines (13) through (19)
Lines (13) through (19) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (13)
Enter the prior year's actual withhold and bonus/incentive payments.

Line (14)
Enter the prior year's withholds and bonuses/incentives that were available for payment in the prior year.

Line (15)
Divides Line (13) by Line (14) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (16)
Equal to Line (14) and is automatically pulled forward.

Line (17)
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of Underwriting Risk–Managed Care Credit FOR THE PRIOR YEAR.

Line (18)
Divides Line (16) by Line (17) to determine the average withhold rate for the prior year.

Line (19)
Multiplies Line (15) by Line (18) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer's withhold/bonus/incentive program in the prior year.

HEALTH, LIFE AND PROPERTY AND CASUALTY

APPENDIX 1 – COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

Incentives, Withhold and Bonus Amounts – Are amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. An incentive arrangement may involve paying an agreed-on amount for each claim (e.g. provider agrees practice in an underserved area). While a bonus arrangement may be paid at the end of a contact period after specific goals have been met. Withhold arrangements can involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Incentive pool, withhold, and bonus amounts are defined as: amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. Some arrangements involve paying an agreed-on amount for each claim, and then paying a bonus at the end of the contract period. Other arrangements involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

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Commented [BC1]: This could also be worded as "(e.g. provider is paid on a per claim basis for practicing in an underserved area.)"

Commented [BC2]: This is directly from the A/S instructions. It used as a basis for the definition drafted above.

Health

UNDERWRITING RISK - Managed Care Credit Calculation

Managed Care Claims Payments	Annual Statement Source	(1) Factor	(2) Paid Claims	(3) Weighted Claims†	(4) Part D Weighted Claims‡
(1) Category 0 - Arrangements not Included in Other Categories	Exhibit 7, Part 1, Column 1, Line 5, in part §	0			
(2) Category 1 - Payments Made According to Contractual Arrangements	Exhibit 7, Part 1, Column 1, Line 6, in part §	0.150			
(3) Category 2a - Subject to Withholds or Bonuses/**Incentives** - Otherwise Categc	Exhibit 7, Part 1, Column 1, Line 7, in part §	*			
(4) Category 2b - Subject to Withholds or Bonuses/**Incentives** - Otherwise Categc	Exhibit 7, Part 1, Column 1, Line 8, in part §	*			
(5) Category 3a - Capitated Payments Directly to Providers		0.600			
(5.1) Capitation Payments - Medical Group - Category 3a	Exhibit 7, Part 1, Column 1, Line 1, in part §				
(5.2) Capitation Payments - All Other Providers - Category 3a	Exhibit 7, Part 1, Column 1, Line 3, in part §				
(6) Category 3b - Capitated Payments to Regulated Intermediaries	Included in Exhibit 7, Part 1, Column 1, Line 2 §	0.600	$0		
(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries	Included in Exhibit 7, Part 1, Column 1, Line 2 §	0.600	$0		
(8) Category 4 - Medical & Hospital Expense Paid as Salary to Providers		0.750			
(8.1) Non-Contingent Salaries - Category 4	Exhibit 7, Part 1, Column 1, Line 9, in part §				
(8.2) Aggregate Cost Arrangements - Category 4	Exhibit 7, Part 1, Column 1, Line 10, in part §				
(8.3) Less Fee For Service Revenue from ASC or ASO	Company Records				
(9) Sub-Total Paid Claims	Exhibit 7, Part 1, Column 1, Lines 13 - 11 - (8.3) - (12) - (13)				
Stand-Alone Medicare Part D Coverage Claim Payments					
(10) Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company Records	XXX	XXX		XXX
(11) Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company Records	XXX	XXX		XXX
(12) Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company Records	0.667			
(13) Category 3a - Federal Reinsurance and Risk Corridor Protection Apply	Company Records	0.767			
(14) Sub-Total Paid Claims	Sum of Lines (10) through (13)				
(15) Total Paid Claims	Sum of Lines (9) and (14)				
(16) Weighted Average Managed Care Discount					
(17) Weighted Average Managed Care Risk Adjustment Factor					

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision Managed Care Discount factor.
‡ This column is for the Medicare Part D Managed Care Discount factor.
§ Stand-Alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.
* The factor is calculated on page XR018.

Denotes items that must be manually entered on filing software.

Health

		Annual Statement Source	(1) Amount
*** Calculation of Category 2 Managed Care Factor**			
(18)	Withhold & Bonus/**Incentive** Payments, ***Prior Year***	Company Records	
(19)	Withhold & Bonuses/**Incentives** Available, ***Prior Year***	Company Records	
(20)	MCC Multiplier - Average Withhold Returned [Line (18)/(19)]		
(21)	Withholds & Bonuses/**Incentives** Available, ***Prior Year***	Company Records	
(22)	Claims Payments Subject to Withhold, ***Prior Year***	Company Records	
(23)	Average Withhold Rate, Prior Year [Line (21)/(22)]		
(24)	MCC Discount Factor, Category 2 Min{.25,[Lines (20) x (23)]}		

* The factor is pulled into Lines (3) and (4) on page XR017.

Denotes items that must be manually entered on filing software.

Life

UNDERWRITING RISK – MANAGED CARE CREDIT

	Comprehensive Medical, Medicare Supplement and Dental Claim Payments	Annual Statement Source	(2) Paid Claims		Factor		(3) Weighted Claims*	(4) Part D Weighted Claims**
(1)	Category 0 - Arrangements not Included in Other Categories	Company records		X	0.000	=		
(2)	Category 1 - Payments Made According to Contractual Arrangements	Company records		X	0.150	=		
(3)	Category 2a - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category 0	Company records		X	†	=		
(4)	Category 2b - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category 1	Company records		X	‡	=		
(5)	Category 3a - Capitated Payments Directly to Providers	Company records		X	0.600	=		
(6)	Category 3b - Capitated Payments to Regulated Intermediaries	Company records		X	0.600	=		
(7)	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Company records		X	0.600	=		
(8)	Category 4 - Medical & Hospital Expense Paid as Salary to Providers	Company records		X	0.750	=		
(9)	Subtotal Paid Claims	Sum of Lines (1) through (8)						
	Stand-Alone Medicare Part D Coverage Claim Payments							
(10)	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company records	XXX	X	xxx	=		XXX
(11)	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company records	XXX	X	xxx	=		XXX
(12)	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company records		X	0.667	=		
(13)	Category 3a - Federal Reinsurance and Risk Corridor Protection apply	Company records		X	0.767	=		
(14)	Subtotal Stand-Alone Medicare Part D Paid Claims	Sum of Lines (10) through (13)						
(15)	Total Paid Claims	Line (9) + Line (14)						
(16)	Weighted Average Managed Care Discount	Column (3) = Column (3) Line (9) / Column (2) Line (9) Column (4) = Column (4) Line (14) / Column (2) Line (14)						
(17)	Weighted Average Managed Care Risk Adjustment Factor	1.0 - Line (16)						

	Calculation of Category 2 Managed Care Factor (Comprehensive Medical and Dental only)		(1) Amount
(18)	Withhold & bonus/**incentive** payments, prior year	Company Records	
(19)	Withhold & bonuses/**incentives** available, prior year	Company Records	
(20)	Managed Care Credit Multiplier – average withhold returned	Line (18) / Line (19)	
(21)	Withholds & bonuses/**incentives** available, prior year	Line (19)	
(22)	Claims payments subject to withhold, prior year	Company Records	
(23)	Average withhold rate, prior year	Line (21) / Line (22)	
(24)	Managed Care Credit Discount Factor, Category 2	Minimum of 0.25 or Line (20) x Line (23)	

† Category 2 Managed Care Factor calculated on Line (24).

‡ Category 2 Managed Care Factor calculated on Line (24) with a minimum factor of 15 percent.

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

** This column is for the Stand-Alone Medicare Part D managed care discount factor.

Denotes items that must be manually entered on the filing software.

Property/Casualty

UNDERWRITING RISK - MANAGED CARE CREDIT PR021

			(2)		(3)	(4)
	Comprehensive Medical, Medicare Supplement and Dental & Vision Claim Payments	Annual Statement Source	Paid Claims	Factor	Weighted Claims†	Part D Weighted Claims††
(1)	Category 0 - Arrangements not Included in Other Categories	Company records	0	0.000	0	
(2)	Category 1 - Payments Made According to Contractual Arrangements	Company records	0	0.150	0	
(3)	Category 2a - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category (	Company records	0	*	0	
(4)	Category 2b - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category	Company records	0	**	0	
(5)	Category 3a - Capitated Payments Directly to Providers	Company records	0	0.600	0	
(6)	Category 3b - Capitated Payments to Regulated Intermediaries	Company records	0	0.600	0	
(7)	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Company records	0	0.600	0	
(8)	Category 4 - Medical & Hospital Expense Paid as Salary to Providers	Company records	0	0.750	0	
(9)	Sub-Total Paid Claims	Sum of Lines (1) through (8)	0		0	
	Stand-Alone Medicare Part D Coverage Claim Payments					
(10.1)	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company records	XXX	XXX		XXX
(10.2)	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company records	XXX	XXX		XXX
(10.3)	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company records	0	0.667		0
(10.4)	Category 3a - Federal Reinsurance and Risk Corridor Protection apply	Company records	0	0.767		0
(10.5)	Sub-Total Paid Claims	Sum of Lines (10.1) through (10.4)	0			0
(10.6)	Total Paid Claims	Sum of Lines (9) and (10.5)	0			
(11)	Weighted Average Managed Care Discount	Col (3) = Col (3) Line (9) / Col (2) Line (9) Col (4) = Col (4) Line (10.5) / Col (2) Line (10.5)			0.000	0.000
(12)	Weighted Average Managed Care Risk Adjustment Factor	Col (3) = 1.0 - Col (3) Line (11) Col (4) = 1.0 - Col (4) Line (11)			0.000	0.000

	Calculation of Category 2 Managed Care Factor		(1) Amount
(13)	Withhold & bonus/**incentive** payments, prior year	Company Records	0
(14)	Withhold & bonuses/**incentives** available, prior year	Company Records	0
(15)	Managed Care Credit Multiplier – average withhold returned	Line (13) / Line (14)	0.000
(16)	Withholds & bonuses/**incentives** available, prior year	Line (14)	0
(17)	Claims payments subject to withhold, prior year	Company Records	0
(18)	Average withhold rate, prior year	Line (16) / Line (17)	0.000
(19)	Managed Care Credit Discount Factor, Category 2	Minimum of 0.25 or Line (15) x Line (18)	0.000

* Category 2 Managed Care Factor calculated on Line (19)

**Category 2 Managed Care Factor calculated on Line (19) with a minimum factor of 15 percent.

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

†† This column is for the Stand-Alone Medicare Part D managed care discount factor.

Denotes items that must be manually entered on the filing software.

PENDING

Comments for Proposal 2021-02-CA are due on March 12, 2021.

Any comments received will be distributed prior to the March 17, 2021 Health Risk-Based Capital (E) Working Group meeting.

February 22, 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 Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide additional analysis regarding the potential investment income adjustment factor for Health H2 Experience Fluctuation Risk.

Incorporation of Investment Income into H2 Risk Factors

As per the HRBC Working Group's request to further analyze the impact of incorporating investment income into Columns 1-4 from page XR012 – Underwriting Experience Fluctuation Risk, we have analyzed expense ratios and claims payment patterns for each type of health coverage.

The table below summarizes the assumed expense ratio for each product, the current base RBC factors, and the implied Risk Factors (i.e., loss ratios at the desired safety margins). The expense ratio assumptions were generated based on a high-level analysis of General Administrative expenses from Page 7 of the annual statement. Additionally, since stand-alone Medicare Part D coverage has effectively no claims lag, the investment income adjustment would be negligible and the RBC factors would not be impacted.

[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.

Expense Ratio Assumption and Current RBC Factor Summary

	Comprehensive Medical	Medicare Supplement	Dental & Vision
Typical Expense Ratio	9.0%	14.0%	13.0%
Tiered RBC Factors			
$0 - $3 Million	0.150	0.105	0.120
$3 - $25 Million	0.150	0.067	0.076
Over $25 Million	0.090	0.067	0.076
Implied Risk Factor (loss ratio)			
$0 - $3 Million	106%	97%	99%
$3 - $25 Million	106%	93%	95%
Over $25 Million	100%	93%	95%

Also, in order to calculate the investment income impact, the following cumulative claims payment patterns were utilized. Since Dental and Vision share a column within the RBC formula, we used a blended completion factor assuming 75% weighting for dental and 25% weighting for vision. The Comprehensive Medical (CM) completion pattern is consistent with our prior analyses.

Claim Payment Pattern Assumption

Months of Run Out	CM	Medicare Supplement	Dental	Vision	*D&V Blended*
0	50%	10%	50%	70%	*55%*
1	70%	75%	85%	92%	*87%*
2	85%	95%	90%	97%	*92%*
3	95%	96%	93%	99%	*95%*
4	97%	97%	95%	100%	*96%*
5	99%	98%	97%	100%	*98%*
6	99%	99%	99%	100%	*99%*
7	100%	100%	100%	100%	*100%*
8	100%	100%	100%	100%	*100%*

Utilizing the same approach described in our previous letters[2] to the HRBC Working Group on this topic, the resulting Tiered RBC factors were calculated using a range of investment return assumptions.

[2] https://www.actuary.org/sites/default/files/2021-01/HEALTHSOLVENCY_Investment_Income_H2_Considerations_to_NAIC_Follow_Up_Letter.pdf; https://www.actuary.org/sites/default/files/2020-12/HEALTHSOLVENCY_Investment_Income_H2_Considerations_Letter_to_NAIC.pdf; https://www.actuary.org/sites/default/files/2020-03/Bond%20Factors%20HRBC%20Horizon%20Results.pdf

Investment Income Adjusted Tiered RBC Factors

Assumed Investment Return	CM	Medicare Supplement	Dental/ Vision
	High Tier (i.e., less than $3M or less than $25M)		
0.0%	15.0%	10.5%	12.0%
0.1%	15.0%	10.5%	12.0%
0.5%	14.9%	10.4%	11.9%
1.0%	14.8%	10.4%	11.9%
1.5%	14.7%	10.3%	11.8%
2.0%	14.7%	10.2%	11.8%
3.0%	14.6%	10.1%	11.7%
	Low Tier		
0.0%	9.00%	6.70%	7.60%
0.1%	8.99%	6.69%	7.59%
0.5%	8.93%	6.63%	7.55%
1.0%	8.87%	6.56%	7.50%
1.5%	8.81%	6.50%	7.45%
2.0%	8.74%	6.43%	7.40%
3.0%	8.61%	6.30%	7.31%

We note that the CM RBC factor changed from 8.60% to 8.61% due to a change in the rounding detail utilized within the calculation. Otherwise, the CM column is unchanged.

*****

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

Number of Companies by Percent Change

.5% Investment Income - Number of Companies by Percentage Change														
0-.5% Change	.5-1% Change	1.1-1.5% Change	1.6%-2% Change	2.1%-2.5% Change	2.6%-3.0% Change	3.1%-3.5% Change	3.6%-4.0% Change	4.1%-4.5% Change	4.6%-5.0% Change	5.1%-5.5% Change	5.6%-6.0% Change	6.1%-6.5% Change	6.6%-7.0% Change	7.1%-7.4% Change
560	309	137	3	2	0	0	0	0	0	0	0	0	0	0

1.0% Investment Income - Number of Companies by Percentage Change														
0-.5% Change	.5-1% Change	1.1-1.5% Change	1.6%-2% Change	2.1%-2.5% Change	2.6%-3.0% Change	3.1%-3.5% Change	3.6%-4.0% Change	4.1%-4.5% Change	4.6%-5.0% Change	5.1%-5.5% Change	5.6%-6.0% Change	6.1%-6.5% Change	6.6%-7.0% Change	7.1%-7.4% Change
369	273	234	63	68	2	0	0	1	1	0	0	0	0	0

1.5% Investment Income - Number of Companies by Percentage Change														
0-.5% Change	.5-1% Change	1.1-1.5% Change	1.6%-2% Change	2.1%-2.5% Change	2.6%-3.0% Change	3.1%-3.5% Change	3.6%-4.0% Change	4.1%-4.5% Change	4.6%-5.0% Change	5.1%-5.5% Change	5.6%-6.0% Change	6.1%-6.5% Change	6.6%-7.0% Change	7.1%-7.4% Change
319	87	131	212	237	17	1	4	1	1	0	1	0	0	0

2.0% Investment Income - Number of Companies by Percentage Change														
0-.5% Change	.5-1% Change	1.1-1.5% Change	1.6%-2% Change	2.1%-2.5% Change	2.6%-3.0% Change	3.1%-3.5% Change	3.6%-4.0% Change	4.1%-4.5% Change	4.6%-5.0% Change	5.1%-5.5% Change	5.6%-6.0% Change	6.1%-6.5% Change	6.6%-7.0% Change	7.1%-7.4% Change
311	44	89	163	177	78	132	8	2	2	0	2	1	1	1

Number of Companies by Point Change

.5% Investment Income - Number of Companies by Point Change													
Less than 0	No Change	0-10 points	11-20 points	21-30 points	31-40 points	41-50 points	51-60 points	61-70 points	71-80 points	81-90 points	91-100 points	More than 100 points	
4	432	506	44	9	5	4	1	3	2	2	0	1	1013

1.0% Investment Income - Number of Companies by Point Change													
Less than 0	No Change	0-10 points	11-20 points	21-30 points	31-40 points	41-50 points	51-60 points	61-70 points	71-80 points	81-90 points	91-100 points	More than 100 points	
4	270	587	108	15	7	8	2	6	2	1	1	2	1013

1.5% Investment Income - Number of Companies by Point Change													
Less than 0	No Change	0-10 points	11-20 points	21-30 points	31-40 points	41-50 points	51-60 points	61-70 points	71-80 points	81-90 points	91-100 points	More than 100 points	
4	270	460	176	48	16	12	4	6	0	4	3	10	1013

2.0% Investment Income - Number of Companies by Point Change													
Less than 0	No Change	0-10 points	11-20 points	21-30 points	31-40 points	41-50 points	51-60 points	61-70 points	71-80 points	81-90 points	91-100 points	More than 100 points	
4	270	339	252	80	21	13	5	7	0	5	3	14	1013

Capital Adequacy (E) Task Force

RBC Proposal Form

[x] Capital Adequacy (E) Task Force
[ ] Catastrophe Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup
[ ] Health RBC (E) Working Group
[ ] Investment RBC (E) Working Group
[ ] P/C RBC (E) Working Group
[ ] Life RBC (E) Working Group
[ ] Longevity Risk (A/E) Subgroup

DATE: 3-17-21	**FOR NAIC USE ONLY**
CONTACT PERSON: Crystal Brown	Agenda Item # 2021-04-CA
TELEPHONE: 816-783-8146	Year 2021
EMAIL ADDRESS: cbrown@naic.org	**DISPOSITION**
ON BEHALF OF: Health RBC (E) Working Group	[ ] ADOPTED
NAME: Steve Drutz	[ ] REJECTED
TITLE: Chief Financial Analyst/Chair	[ ] DEFERRED TO
AFFILIATION: WA Office of Insurance Commissioner	[ ] REFERRED TO OTHER NAIC GROUP
ADDRESS: PO Box 40255	[ ] EXPOSED
Olympia, WA 98504-0255	[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[x] Health RBC Blanks
[x] Health RBC Instructions
[x] Property/Casualty RBC Blanks
[x] Property/Casualty RBC Instructions
[x] Life and Fraternal RBC Instructions
[x] Life and Fraternal RBC Blanks
[ ] OTHER _____

DESCRIPTION OF CHANGE(S)

Incorporate investment income into the Underwriting Risk – Experience Fluctuation Risk factors for columns 1-3. The base underwriting factors would be adjusted for Comprehensive Medical, Medicare Supplement and Dental and Vision.

REASON OR JUSTIFICATION FOR CHANGE **

Incorporated investment income into Columns 1-3 on the Underwriting Risk – Experience Fluctuation Risk page. The American Academy of Actuaries provided recommended factors to the Working Group. The Academy found that due to no claims lag in Stand-Alone Medicare Part D coverage, the investment income adjustment would be negligible and the RBC factors would not be impacted.

The Working Group will continue to work with the Academy to look at the potential to incorporate an investment income adjustment to the factors for the other health lines of business for 2022 or later.

Additional Staff Comments:

These changes will also need to be incorporated into the Life and P/C formula.

**** This section must be completed on all forms.** **Revised 2-2019**

UNDERWRITING RISK - L(1) THROUGH L(21)
XR012

Underwriting Risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

Underwriting risk is present when the next dollar of unexpected claim payments comes directly out of the reporting entity's capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, a reporting entity may charge an individual $100 in premium in exchange for a guaranty that all medical costs will be paid by that reporting entity. If the individual incurs $101 in claims costs, the reporting entity's surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula, therefore, requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. Appendix 1 contains commonly used terms for general types of health insurance. Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for terms specifically used with respect to Medicare Part D coverage of prescription drugs.

Claims Experience Fluctuation

The RBC requirement for claims experience fluctuation is based on the greater of the following calculations:

A. Underwriting risk revenue, times the underwriting risk claims ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at $750,000 per individual and $1,500,000 total for medical coverage; $25,000 per individual and $50,000 total for all other coverage except Medicare Part D coverage and $25,000 per individual and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using

the health organization's actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports, the RBC results for all of the formula components shall be calculated using actual data.

L(1) through L(21)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; and (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

Column (1) - Comprehensive Medical & Hospital. Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Column (2) - Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

Column (3) - Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

Column (4) - Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR014. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

Column (5) – Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, **NOT INCLUDED ABOVE** that have not been specifically addressed in the other columns listed above.

Column (6) - Other Non-Health Coverages. This includes life and property and casualty coverages.

The following paragraphs explain the meaning of each line of the table for computing the experience fluctuation underwriting risk RBC.

Line (1) Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage.

> **NOTE**: Where premiums are paid on a monthly basis, they are generally fully earned at the end of the month for which coverage is provided. In cases where the mode of payment is less frequent than monthly, a portion of the premium payment will be unearned at the end of any given reporting period.

Line (2) Title XVIII Medicare. This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

Line (3) Title XIX Medicaid. This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Stand-Alone Medicare Part D coverage of low-income enrollees is not included in this line.

Line (4) Other Health Risk Revenue. This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.

Line (5) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

Line (6) Underwriting Risk Revenue. The sum of Lines (1) through (4) minus Line (5).

Line (7) Net Incurred Claims. Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to

members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR014.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims. Line (7) minus Line (8).

Line (10) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (11) Underwriting Risk Incurred Claims. Line (9) minus Line (10).

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income for xx% investment return.

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

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The factors for the highlighted items to the left will be updated based on either Option 1 or Option 2.

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Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future

claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount. Line (14) x Line (15).

Line (17) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.

- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to $750,000 less retention).

If there is no specific stop-loss or reinsurance in place, enter $9,999,999.

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention)	$100,000
Reinsurance Coverage	90% of $500,000 in excess of $100,000
Maximum reinsured coverage	$600,000 ($100,000 + $500,000)

Maximum Ret. Risk =	$100,000	deductible
	+ $150,000	($750,000 – $600,000)
	+ $ 50,000	(10% of ($600,000 – $100,000) coverage layer)
	= $300,000	

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention)	$75,000
Reinsurance Coverage	90% of $1,000,000 in excess of $75,000

Maximum reinsured coverage	$1,075,000 ($75,000 + $1,000,000)	
Maximum Ret. Risk =	$ 75,000	deductible
	+ 0	($750,000 – $1,075,000)
	+ $ 67,500	(10% of ($750,000 –$75,000)) coverage layer)
	= $142,500	

Line (18) Alternate Risk Charge. This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.

Line (19) Alternate Risk Adjustment. This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (20) Net Alternate Risk Charge. This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

Line (21) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

UNDERWRITING RISK

Option 1 - 0.5% Investment Return

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	**0.1490**	**0.1040**	**0.1190**	0.251	0.130	0.130
$3 - $25 Million	**0.1490**	**0.0663**	**0.0755**	0.251	0.130	0.130
Over $25 Million	**0.0893**	**0.0663**	**0.0755**	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.

UNDERWRITING RISK

Option 2 - 1.0% Investment Return

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	**0.1480**	**0.1040**	**0.1190**	0.251	0.130	0.130
$3 - $25 Million	**0.1480**	**0.0656**	**0.0750**	0.251	0.130	0.130
Over $25 Million	**0.0887**	**0.0656**	**0.0750**	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.