



Date: 8/30/2022

Virtual Meeting

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP

Friday, September 9, 2022

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	Tish Becker	Kansas
Matthew Richard/Aaron Hodges	Texas	Danielle Smith/Debbie Doggett	Missouri
Co-Vice Chairs		Michael Muldoon	Nebraska
Wanchin Chou	Connecticut	Tom Dudek	New York
Carolyn Morgan/Kyle Collins	Florida	Jefferey Smith	Pennsylvania

NAIC Support Staff: Crystal Brown

AGENDA

1. Consider Adoption of its July 21 (in lieu of Summer National Meeting) Minutes— *Steve Drutz (WA)* Attachment One
2. Consider Exposure of Preferred Stock Instructions Proposal (2022-10-H)—*Steve Drutz (WA)* Attachment Two
3. Consider Exposure of Underwriting Risk-Experience Fluctuation Risk – Analysis of Analysis of Operations Proposal (2022-11-H)—*Steve Drutz (WA)* Attachment Three
4. Discuss Next Steps in H2-Underwriting Risk Project—*Steve Drutz (WA)* Attachment Four
5. Discuss Request for Input Regarding Runoff Companies—*Steve Drutz (WA)* Attachment Five
6. Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*
7. Adjournment

Draft: 7/25/22

Health Risk-Based Capital (E) Working Group
Virtual Meeting (*in lieu of meeting at the 2022 Summer National Meeting*)
July 21, 2022

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 21, 2022. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard and Aaron Hodges, Co-Vice Chairs (TX) Wanchin Chou (CT); Tish Becker (KS); Michael Muldoon (NE); and Tom Dudek and Frank Horn (NY).

1. Adopted is May 11, May 4, and April 20 Minutes

The Working Group met May 11, May 4, and April 20. During these meetings, the Working Group took the following action: 1) heard a presentation from the American Academy of Actuaries (Academy) on the methodologies considered in the H2 – Underwriting Risk review; 2) exposed the affiliated investment instructions and blanks; 3) received an update on the Health Test Ad Hoc Group and Excessive Growth Charge Ad Hoc Group; 4) heard a presentation from AM Best on Best’s Capital Adequacy Ratio (BCAR); and 5) adopted its Spring National Meeting minutes.

Mr. Chou made a motion, seconded by Mr. Dudek, to adopt the Working Group’s May 11 (Attachment **Two-A**), May 4 (Attachment **Two-B**), and April 20 (Attachment **Two-C**) minutes. The motion passed unanimously.

2. Adopted its Revised 2022 Working Agenda

Mr. Drutz said the working agenda was revised to add the “review of the affiliated investment” as a new item. This item was given a priority status of 1 and an expected completion date of year-end 2023.

Mr. Chou made a motion, seconded by Mr. Muldoon, to adopt the revised 2022 working agenda. The motion passed unanimously.

3. Adopted its 2022 Newsletter

Mr. Drutz said the 2022 health risk-based capital (RBC) newsletter reflects the adopted proposal and editorial changes for year-end 2022. He said the newsletter appears different from past years; the purpose of the adoption is to consider the content of the newsletter as the format will later be revised. He said that when the formatting of the newsletter is complete, it will be posted to the Working Group’s web page.

Mr. Dudek made a motion, seconded by Mr. Muldoon, to adopt the 2022 health RBC newsletter. The motion passed unanimously.

4. Adopted the 2021 Health RBC Statistics

Mr. Drutz said the 2021 health statistics were run on July 1. He said there were 1,095 health RBC filings loaded onto the NAIC database, up from 1,067 in 2020. Mr. Drutz said there were 12 companies that triggered an action level in 2021: five were in a company action level; two were in a regulatory action level; two were in an authorized

control level (ACL); and three were in a mandatory control level. Mr. Drutz said there were 15 companies that triggered the trend test, and the ACL and total adjusted capital (TAC) amounts increased from 2020 to 2021.

Mr. Drutz said there were revisions to the statistics report to create consistency across life, property/casualty (P/C) and health statistical reports. He noted that the column for “Excluding ACA Fee” was removed due to the removal of the federal Affordable Care Act (ACA) fee sensitivity test from the health RBC formula in 2021. He said two new categories were added to the statistics: 1) “# of Companies with and RBC Ratio of <300% and >250%”; and 2) “# of companies with an RBC ratio of <250% and >200%.” These categories will replace the category “# of companies with an RBC ratio of <300% & > 200%.”

Mr. Muldoon made a motion, seconded by Mr. Chou, to adopt the 2021 health RBC statistics report. The motion passed unanimously.

5. Referred the Health Affiliated Investments Instructions and Blank to the Capital Adequacy (E) Task Force

Mr. Drutz said that during its May 4 meeting, the Working Group exposed the affiliated investment instructions and blanks changes for a 61-day comment period. There were no comments received.

Mr. Hodges made a motion, seconded by Mr. Dudek, to refer the health affiliated instructions and blanks to the Capital Adequacy (E) Task Force for discussion. The motion passed unanimously.

6. Exposed the Academy’s Response on the H2 - Underwriting Risk Review

Mr. Drutz said the Working Group heard presentations from AM Best and the Academy on the different methodologies considered in the Academy’s report of the H2 - Underwriting Risk review. He said that because of those presentations, the Working Group requested the Academy provide its recommended approach and timeline for moving forward with the project. Matthew Williams (Academy) gave a summary of the letter (Attachment) and said that he would take any questions or comments back to the Academy Health Solvency Subcommittee. He said the estimated time frame to complete the work was 18 weeks given the complexity of the project. Mr. Drutz asked if the Academy would be able to use the Analysis of Operations page given the adopted changes to break out comprehensive medical into group and individual, which will be effective for year-end 2023. Mr. Drutz also asked if the other underwriting business and limited benefit plans would be able to be incorporated or later reviewed if the Academy were to have the data needed for this business. Mr. Williams agreed to bring these questions back to the Academy to discuss.

Hearing no objections, the Working Group agreed to expose the Academy letter for a 30-day comment period ending Aug. 22.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/

Capital Adequacy (E) Task Force**RBC Proposal Form**

- | | | |
|-------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input checked="" type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

DATE: <u>8-19-22</u>	<u>FOR NAIC USE ONLY</u>
CONTACT PERSON: <u>Crystal Brown</u>	Agenda Item # <u>2022-10-H</u>
TELEPHONE: <u>816-783-8146</u>	Year <u>2023</u>
EMAIL ADDRESS: <u>cbrown@naic.org</u>	<u>DISPOSITION</u>
ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Grp</u>	<input type="checkbox"/> ADOPTED _____
NAME: <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
TITLE: <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION: <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
ADDRESS: <u>5000 Capitol Blvd SE</u>	<input type="checkbox"/> EXPOSED _____
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

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

- | | | |
|-------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input checked="" type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION OF CHANGE(S)

Update preferred stock instructions to delete reference to bond factors and revised for consistency with P/C RBC preferred stock instructions.

REASON OR JUSTIFICATION FOR CHANGE **

The purpose of the change is to add clarity to the preferred stock instructions with regard to the bond factors changes for increased granularity.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 7-2022

EQUITY ASSETS
XR010

Unaffiliated Preferred Stocks

~~Experience data to develop preferred stock factors is not readily available; however, it is believed that preferred stocks are somewhat more likely to default than bonds. The loss on default would be somewhat higher than that experienced on bonds; however, formula factors are equal to bond factors.~~

~~The RBC requirements for unaffiliated preferred stocks are based on the NAIC designation. Detailed information on unaffiliated preferred stock is found in~~ Column (1) amounts ~~are~~ from Schedule D, Part 2, Section 1 not including affiliated preferred stock. The preferred stocks must be broken out by asset designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines. The total amount of unaffiliated preferred stock reported should equal annual statement Page 2, Column 3, Line 2.1, less any affiliated preferred stock in Schedule D Summary by Country, Column 1, Line 18.

Capital Adequacy (E) Task Force**RBC Proposal Form**

- Capital Adequacy (E) Task Force Health RBC (E) Working Group Life RBC (E) Working Group
 Catastrophe Risk (E) Subgroup Investment RBC (E) Working Group Longevity Risk (A/E) Subgroup
 Variable Annuities Capital. & Reserve (E/A) Subgroup P/C RBC (E) Working Group RBC Investment Risk & Evaluation (E) Working Group

DATE: <u>8-19-22</u>	<u>FOR NAIC USE ONLY</u>
CONTACT PERSON: <u>Crystal Brown</u>	Agenda Item # <u>2022-11-H</u>
TELEPHONE: <u>816-783-8146</u>	Year <u>2023</u>
EMAIL ADDRESS: <u>cbrown@naic.org</u>	<u>DISPOSITION</u>
ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Grp</u>	<input type="checkbox"/> ADOPTED _____
NAME: <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
TITLE: <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION: <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
ADDRESS: <u>5000 Capitol Blvd SE</u>	<input type="checkbox"/> EXPOSED _____
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

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

- Health RBC Blanks Property/Casualty RBC Blanks Life and Fraternal RBC Instructions
 Health RBC Instructions Property/Casualty RBC Instructions Life and Fraternal RBC Blanks
 OTHER _____

DESCRIPTION OF CHANGE(S)

Update the annual statement source descriptions and align the lines of business to the changes in the Analysis of Operations based on Blanks proposal 2021-17BWGMOD on page XR013, XR014.

REASON OR JUSTIFICATION FOR CHANGE **

Align the Health RBC formula with Annual Statement changes to the Analysis of Operations.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 7-2022

UNDERWRITING RISK - L(1) THROUGH L(21) XR013

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 (hospital & medical individual & group) (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 & Medical) individual & group; (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 & Medical) Individual & Group. 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 & medical) individual & group.

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 XR015. 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 XR015.

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) through (3) have incorporated an investment income yield of 0.5%.

	\$0 – \$3 Million	\$3 – \$25 Million	Over \$25 Million
Comprehensive Medical & (Hospital & Medical) <u>Individual & group</u>	0.1493	0.1493	0.0893
Medicare Supplement	0.1043	0.0663	0.0663
Dental & Vision	0.1195	0.0755	0.0755
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

The investment income yield was incorporated into the Comprehensive ~~Medical & (Hospital & Medical)~~ individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond ([U.S. Department of the Treasury](#)) on each Monday through the month of January and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

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

Line (15) Managed Care Discount. For Comprehensive ~~Medical & (Hospital & Medical) individual & group~~, 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 =	$ \begin{aligned} & \$100,000 \quad \text{deductible} \\ & + \$150,000 \quad (\$750,000 - \$600,000) \\ & + \$50,000 \quad (10\% \text{ of } (\$600,000 - \$100,000) \text{ coverage layer}) \\ & = \$300,000 \end{aligned} $

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).

OTHER UNDERWRITING RISK – L(22) THROUGH L(45) XR015–XR017

In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when reporting entities guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e., Comprehensive (Hospital & Medical) individual & group, Medicare Supplement, Dental/Vision, Stand-Alone Medicare Part D Coverage, Supplemental benefits within Medicare Part D Coverage, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the Federal Employees Health Benefit Program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by two percent to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive (Hospital & Medical) individual & group. It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive (Hospital & Medical) individual & group. A factor of 35 percent will be applied to the first \$25,000,000 in premium and a factor of 25 percent will be applied to premium in excess of \$25,000,000.

Line (25.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in INT 05-05: Accounting for Revenue under Medicare Part D Coverage) for the incurred claims associated with the beneficiaries for these supplemental drug benefits.

Line (25.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital Working Group however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2 percent factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR013, Column (1), Line (5).

Lines (26) through (32) Disability Income. Disability Income Premiums are to be separately entered depending upon category (Individual and Group). For Individual Disability Income, a further split is between noncancellable (NC) or other (guaranteed renewable, etc.). For Group Disability Income, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below \$50,000,000 for similar types. In determining the premiums subject to the higher factors, Individual Disability Income NC and Other are combined. All types of Group and Credit Disability Income are combined in a different category from Individual.

UNDERWRITING RISK

Experience Fluctuation Risk

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Line of Business	Comprehensive (Hospital & Medical) - Individual & Group	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health	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 (Hospital & Medical) - Individual & Group	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
\$0 - \$3 Million	0.1493	0.1043	0.1195	0.251	0.130	0.130
\$3 - \$25 Million	0.1493	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	\$50,000	\$50,000	\$150,000	\$50,000	N/A
	or	or	or	or	or	
	2 x Maximum Individual Risk	2 x Maximum Individual Risk	2 x Maximum Individual Risk	6 x Maximum Individual Risk	2 x Maximum Individual Risk	

Denotes items that must be manually entered on filing software.


† The Annual Statement Sources are found on page XR014.

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

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


† Annual Statement Source

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Line of Business	Comprehensive (Hospital & Medical) - Individual & Group	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non- Health	Total
(1) Premium	Page 7, Columns 2 & 3, Lines 1 + 2	Page 7, Column 4, Line 1 + 2	Page 7, Columns 5 & 6, Line 1 + 2			Page 7, Column 14, Lines 1 + 2	
(2) Title XVIII-Medicare	Page 7, Column 8, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 7, Lines 1 + 2
(3) Title XIX-Medicaid	Page 7, Column 9, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 8, Lines 1 + 2
(4) Other Health Risk Revenue	Page 7, Columns 2 & 3, Line 4	XXX	Page 7, Columns 5 & 6, Line 4			XXX	
(7) Net Incurred Claims	Page 7, Columns 2 + 3 + 7 + 8, Line 17	Page 7, Column 4, Line 17	Page 7, Columns 5 & 6, Line 17			XXX	
(10) Fee-For-Service Offset	Page 7, Columns 2 & 3, Line 3	XXX	Page 7, Columns 5 & 6, Line 3			XXX	
(17) Maximum Per-Individual Risk After Reinsurance	Gen Int Part 2 Lines 5.31 + 5.32	Gen Int Part 2 Line 5.33	Gen Int Part 2 Line 5.34			XXX	XXX

 Denotes items that must be manually entered on filing software.

Limited Benefit Plans (Individual and Group Combined)		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
(42)	Hospital Indemnity and Specified Disease	Included in Page 7, Column 13 , Line 1 and 2, in part		0.035	
(42.1)	\$50,000 if Line (42) is Greater Than Zero				
(42.2)	Total Hospital Indemnity and Specified Disease	Lines (42) + (42.1)			
(43)	Accidental Death & Dismemberment	Included in Page 7, Column 13 , Line 1 and 2, in part			
(43.1)	First \$10 Million Earned Premium of Line (43)			0.055	
(43.2)	Over \$10 Million Earned Premium of Line (43)			0.015	
(43.3)	Maximum Retained Risk for Any Single Claim	Company Records			
(43.4)	Three Times Line (43.3)				
(43.5)	Lesser of Line (43.4) or \$300,000				
(43.6)	Total AD&D	Lines (43.1) + (43.2) + (43.5)			
(44)	Other Accident	Included in Page 7, Column 13 , Line 1 and 2, in part		0.050	
(45)	Premium Stabilization Reserves	Included in U&I, Part 2D, Column 1, Line 4		-0.500	Φ
(46)	Total Other Underwriting Risk	Lines (25.3) + (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3) + (41) + (42.2) + (43.6) + (44) + (45)			

Φ This is limited to the Total Net Underwriting RBC on XR013, Column (7), Line (21) Less Column (4), and XR015, Column (2), Lines (25.3), (26.3), (27.3), (28.3), (29.3), (30.6), (31.3), (32.3), XR016 Column (2), Line (36) and XR017 Column (2), Lines (42.2), (43.6), and (44).

 Denotes items that must be manually entered on filing software.



AMERICAN ACADEMY of ACTUARIES

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July 13, 2022

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

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy)¹ Health Solvency Subcommittee (“subcommittee”), I am pleased to provide this letter to the NAIC Health Risk-Based Capital (E) Working Group (“working group”). The subcommittee drafted this letter in response to the request from the working group after its [previous report](#) to provide a timeline to analyze and comprehensively review the H2—Underwriting Risk component and the managed care credit calculation in the health risk-based capital (HRBC) formula.

The subcommittee’s [January 2022 report](#) included the following six recommendations for the HRBC Working Group’s consideration:

1. Refresh factors based on updated insurer data
2. Develop factors at a more granular product level
3. Develop factors specific to more relevant block sizes and consider an indexing factor for cut points to change over time
4. Model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly
5. Refresh of managed care credit formula and factors to be more relevant and reflective of common contracting approaches and other risk factors associated with these contracting approaches
6. Analyze long-term care insurance (LTCI) underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time

The subcommittee plans to proceed with an analysis to support recommendations 1-5 above across three work tracks. Concerning recommendation No. 6, the subcommittee suggests that the working group discuss any potential changes to LTCI risk factors with the NAIC Life Risk-

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.

Based Capital (E) Working Group because most LTCI premium is written on life blanks. Please revisit the previous report for additional detail related to the six recommendations.

The three work tracks that will be needed to support the recommendations are:

1. Redesign HRBC Pages XR013/XR014 (Experience Fluctuation Risk)²
2. Develop Tiered RBC Factors
3. Redesign HRBC Pages XR018/XR019 (Managed Care Credit)

As the subcommittee completes each work track, it will share the results with the working group for their consideration and feedback. The remainder of this letter provides more details regarding our proposed analyses.

1. HRBC Pages XR013 and XR014 (Experience Fluctuation Risk) redesign

The current RBC formula for Experience Fluctuation Risk utilizes data from Page 7—Analysis of Operations by Line of Business—then aggregated to six product columns instead of the nine shown on Page 7. Alternatively, the RBC formula could use the Supplemental Health Care Exhibit (“SHCE”)—Part 1, the Accident and Health Policy Experience Exhibit (“A&H Exhibit”), or the Exhibit of Premiums, Enrollment, and Utilization. While the SHCE and A&H Exhibits benefit from additional product detail, the limitation is that they are not filed until April 1—after insurers have filed their RBC calculations. The alternative—the Exhibit of Premiums, Enrollment, and Utilization—is limited by the fact that premiums and claims are presented on a gross basis.

Given that the later timing of the supplements would create a mismatch in timing between the RBC calculation and the availability of data, the subcommittee would suggest utilizing Exhibit of Premiums, Enrollment, and Utilization, at least until insurers file the supplements with the rest of the core financial statement pages.

The subcommittee will likely need to make some adjustments during the risk factor development process (e.g., utilizing data from the historical supplements or other sources) to remedy the gross basis presentation. Additionally, for the RBC filing, Company Records may be required to move from gross to net premiums and claims. Lastly, given the significant A&H volume on life blanks, the Analysis of Operations by Lines of Business—Accident and Health would likely need to be utilized.

Additional changes to XR013/XR014 would include:

- Company-specific experience adjustments, based on historical company-specific experience—likely between five and 10 years
- An adjustment for investment income, tailored to the cash flows of health products
- A premium diversification discount factor

² Based on the 2021 HRBC formula and layout. Additionally, the subcommittee does not expect to make changes to XR015 as part of this exercise given potential data limitations on the Supplemental pages and the Exhibit of Premiums, Enrollment, and Utilization.

- Adjustments to the tiering thresholds

This work track would produce a brief discussion document with a corresponding workbook with the proposed calculation and health blank data sourcing with mock data. The subcommittee expects this work track to take approximately 18 weeks, given the complexity of the redesign.

2. Tiered RBC factor development

The development of the new Tiered RBC factors would be conceptually similar to the exercise performed by the Academy's Property and Casualty Risk-Based Capital Committee for the P&C RBC formula. That is, the premium risk factors would reflect the risk that the subsequent year³ of net premium would produce adverse underwriting experience. The Premium Risk Factors for each line of business would be derived from the net loss ratio for each company that has submitted statutory financials over some predefined period (potentially up to 10 years). The premium risk factors would correspond to some percentile confidence level, as determined by the working group.

This work track would ultimately produce a brief discussion document with a corresponding workbook summarizing the data and results for each line of business at various confidence levels. Given the time needed for data collection and analysis, the subcommittee expects this work track to take approximately 28 weeks.

3. HRBC XR018 and XR019 (Managed Care Credit) redesign

As discussed in the previous January 2022 report, the current Managed Care Credit does not reflect the current nature of provider contracts or contractual risk-sharing provisions. As a result, the subcommittee recommended that the Managed Care Credit be updated. Given the limited data collected within Exhibit 7, this exercise would only include the design of a new HRBC page based on company records (or potentially a new health blank exhibit) for the working group's consideration. As the new data is collected, the new Managed Care Credit could eventually be incorporated into the Experience Fluctuation Risk calculation. Alternatively, to accelerate the redesigned Managed Care Credit adoption, the working group could ask that the subcommittee estimate both the effectiveness of each Managed Care mechanism (and the corresponding discount factor) and the industry distribution of claim payment based on Exhibit 7 reporting. This estimation would require some speculation, which may be inaccurate once the NAIC collects and analyzes data in the future.

This work track would produce a brief discussion document with a corresponding workbook with the proposed Managed Care Credit data collection template and calculation. The subcommittee expects this work track to take approximately 18 weeks, given the complexity of the redesign.

³ This one-year time horizon would imply that contractual obligations and pricing are generally locked in for a year; however, the NAIC may consider (and request) an alternative time horizon

4. Next Steps

The subcommittee would like to discuss the timing of this work and data availability with the working group. The subcommittee would also like to discuss the approach for factor development—namely:

- Which schedules from the health blanks should be utilized for the Experience Fluctuation Risk calculation? Relatedly, is there any receptivity to either delaying the RBC calculation until the supplemental reports are filed or to accelerating the timing of when the supplemental reports need to be filed?
- Should the Managed Care Credit changes be included as part of this Experience Fluctuation Risk refresh or later, when data becomes available?

Thank you for the opportunity to provide this response to the request of the working group to provide a work plan to perform an update for the Experience Fluctuation Risk calculations. Members of the subcommittee welcome the opportunity to speak with you in more detail and answer any questions you might have regarding this letter. If you would like to discuss this letter and its recommendations, 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
cbrown@naic.org



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January 21, 2022

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

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and
Managed Care Credit Calculation in 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 report to the National Association of Insurance Commissioners (NAIC) Health Risk-Based Capital (HRBC) (E) Working Group. This report is in response to the [request](#) from the working group to analyze and comprehensively review the H2—Underwriting Risk component and the managed care credit calculation in the health risk-based capital (RBC) formula.

1. Introduction

In this report, the subcommittee presents a discussion of the current H2 — Underwriting Risk factors, key changes affecting health insurers that have impacted underwriting risk since the factors were originally developed, alternative views of underwriting risk from other regulating entities, and a set of targeted recommendations for improving the H2 — Underwriting Risk factors.

Our approach surveyed other methods of evaluating risk, and in particular underwriting risk taken by other risk quantification formulas (e.g., health, life, property and casualty (P&C) RBC formulas; credit rating agencies) and summarized their respective merit for health underwriting risk. The subcommittee recommends a constructive dialogue with the NAIC's HRBC Working Group to determine the best approach before beginning detailed analysis and factor development.

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.

2. Review of the H2 Risk Factor in Current HRBC Formula

History of H2 in Health Organizations' Risk- Based Capital Formula

In the early 1990s, the Academy fulfilled a request from the NAIC to assist in the development of a risk-based capital formula - similar to those in place for life Insurers and P&C Insurers - that could be applied to a variety of traditional and nontraditional risk-assuming enterprises in the health insurance space. The objective in developing an RBC formula was to calculate the minimum amount of capital that the reporting entity should hold to support the risk associated with the business venture. In doing so, monitoring and regulatory agencies would be able to identify entities that were exhibiting signals of financial weakness and could take steps to promote their solvency. The RBC formula was also to be constructed in such a way that results would be the same for companies engaged in the same health insurance business activity, regardless of organizational structure.

Over time, refinements have been made leading to today's health risk-based capital (HRBC) model. Like the life and P&C risk-based capital formulas, multiple risk categories are included in the calculation of the minimum capital amount for an entity. In the case of HRBC, five categories are employed (emphasis added to H2 - Underwriting Risk):

Category Title	Abbreviation	Definition
Insurance Affiliates and Misc. Other	H0	This is the risk from the declining value of insurance subsidiaries as well as risk from off-balance sheet and other miscellaneous accounts (e.g., deferred tax assets (DTAs)).
Asset Risk - Other	H1	This is the risk of asset losses due to default of principal and interest or fluctuation in market value.
Underwriting Risk	H2	This is the risk of underestimating liabilities from business already written or inadequately pricing business to be written in the coming year.
Credit Risk	H3	Creditor risk of not recovering receivable amounts owed
Business Risk	H4	This category includes several miscellaneous risks not captured elsewhere, such as those associated with administrative expenses, administrative services contracts/administrative services only (ASC/ASO) business, guaranty fund assessment, and excessive growth.

To develop the original H2 (underwriting risk) component of the HRBC formula, the Academy employed statistical modeling based on health insurance and provider data available at that time. Stochastic modeling was performed using a five-year modeling time horizon, and formulas and factors were developed to calculate capital levels that allowed each product to remain solvent in 95% of the modeled scenarios. Ultimately, the original modeling was used to develop relative risk values (RVs) for most lines of business which would be referenced by the NAIC to establish risk factors, based on the NAIC's risk tolerance.

Calculation of H2 in HRBC Formula

The total H2 risk charge is calculated through several sub-formulas within the HRBC calculation, denoted as XR013 through XR019. The following is a summary of each sub-formula that contributes to the overall calculation of H2 for a reporting entity:

XR013 — Underwriting Risk

For most health reporting entities, underwriting risk constitutes the largest share of the overall risk-based capital charge, representing the general risk of fluctuations in underwriting experience —i.e., the risk that premiums (which are an expected value of future costs and considerations) are insufficient to cover actual plan costs. In such a scenario, the next dollar of cost is funded by the reporting entity's capital and surplus. Depending on the policy type and the level of provider contracting, the reporting entity may not be fully exposed to this potential fluctuation in claims experience, as the risk may be transferred to another entity (e.g., a provider group or a reinsurer). However, this could introduce a separate and material credit risk that the assuming entity may default on its obligation(s).

To calculate the charge for this risk, six general lines of business are utilized:

1. Comprehensive Medical & Hospital
2. Medicare Supplement
3. Dental and Vision
4. Stand-alone Medicare Part D Coverage
5. Other Health Coverages
6. Other Non-Health Coverages

For each line of business, risk factors are applied to the reported incurred claims for the reporting entity, sourced from the Annual Statement. The risk factors are the same for all reporting entities, but generally decrease as the premiums for a particular line of business increases. Applying the risk factors to the estimated incurred claims generates Base Underwriting Risk RBC. See an illustration in Table 1 of the Underwriting Risk Factors by premium tier:

Table 1.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical & Hospital	0.1493	0.1493	0.0893
Medicare Supplement	0.1043	0.0663	0.0663
Dental & Vision	0.1195	0.0755	0.0755
Stand-Alone Medicare Part D Coverage	0.2510	0.2510	0.1510
Other Health	0.1300	0.1300	0.1300
Other Non-Health	0.1300	0.1300	0.1300

To the subcommittee's collective knowledge, aside from the adoption of investment income adjustments into the Comprehensive Medical & Hospital, Medicare Supplement, and Dental and Vision factors in 2021, the premium tiers have not been adjusted over time to capture market dynamics that influence risk, such as medical cost growth.

A Managed Care Credit (sourced from XR018) is then applied to the Base Underwriting Risk RBC, which can reduce the risk charge for certain lines of business if the managed care contracts in place limit the financial risk of adverse claims fluctuations on the reporting entity.

The ultimate calculation of Net Underwriting Risk RBC compares the calculated Underwriting Risk (including the Managed Care Credit) to an Alternate Risk Charge that is dependent on the amount of risk borne by the reporting entity, after adjusting for any reinsurance arrangements.

XR014 — Annual Statement Source

This page contains no RBC calculations; however, it does illustrate to the user where information can be retrieved to perform RBC calculations on XR013. Some pieces of information are obtained from the reporting entity's annual statement, while others must be sourced from internal company records (e.g., all premium and claims data for stand-alone Medicare Part D coverage).

XR015 — Other Underwriting Risk

This page contains the risk charge calculation for the following, where the risk charge, unless otherwise specified, is a risk factor applied to earned premium:

1. Business with rate guarantees split by a rate guarantee period of 15 to 36 months and a rate guarantee period of over 36 months
2. Federal Employees Health Benefits Program (FEHBP) and TRICARE, where the risk factors are applied to incurred claims
3. Stop Loss and Minimum Premium
4. Supplemental Benefits within Stand-Alone Medicare Part D Coverage, where the risk factors are applied to incurred claims
5. Medicaid pass-thru payments reported as premium
6. Disability income split by the first \$50 million in earned premium and earned premium over \$50 million for the following with the risk factor varying by premium tier:
 - a. Noncancellable morbidity risk
 - b. Other than non-cancellable morbidity risk
 - c. Credit monthly balance plans
 - d. Group long-term
 - e. Credit single premium with additional reserves
 - f. Credit single premium without additional reserves
 - g. Group short-term

For single premium credit insurance with additional reserves, the premium is reduced for the change in additional reserves held.

The premium and additional reserves used in the risk charge calculation are based on company records.

XR016 — Long-Term Care (LTC) Insurance Premium/Loss Ratio Experience

The majority of the risk charge is for morbidity risk plus an additional risk charge for rate risk on noncancellable LTC insurance. The rate risk factor is 0.100 for all noncancellable premium and the morbidity charge is 0.100 and 0.030 for all LTC insurance premiums up to \$50 million and over \$50 million, respectively.

Then, additional charges for morbidity risk are based on experience. The average loss ratio is calculated for the current and prior year. Actual claims are adjusted to the average loss ratio and this adjusted claim amount is used to calculate the risk charge. The risk charge is calculated as follows:

1. For the first \$35 million, the risk factor is 0.250 if current year premium is positive; otherwise, the factor is 0.370.
2. For adjusted claims in excess of \$35 million, the risk factor is 0.080 if current year premium is positive; otherwise, the factor is 0.120.
3. A risk factor of 0.050 is applied to LTC Insurance claim reserves.

The premium and claim information used in the risk charge calculation are based on company records.

XR017 — Limited Benefit Plan

This page contains the risk charge calculation for the following limited benefit plans:

1. Hospital Indemnity and Specified Disease
2. Accidental Death and Dismemberment
3. Other Accident
4. Premium Stabilization Reserves—this is a credit to RBC and it is limited to the total Underwriting RBC for all lines, excluding stand-alone Part D.

The premium and reserve information used in the risk charge calculation are based on company records.

XR018 — Underwriting Risk — Managed Care Credit

The managed care credit seeks to account for volatility in claims costs relative to the coverage period. For instance, if an actuary was aware of capitation rates during the rating cycle, that would improve the likelihood of rate adequacy.

The managed care credit calculation utilizes five factors that reflect the impact of different types of provider contracts on medical claim predictability and volatility. The factor associated with each contract category is applied to the level of incurred claims in that category and an overall discount or credit is calculated based on the relative claims weights. The discount factors have remained unchanged since they were first adopted.

For example, fully capitated provider contracts (i.e., when providers are accepting 100% of the underwriting risk) are generally assumed to provide a health insurer with substantial financial protection and, accordingly, the substantial credit noted in the below table. Other provider contracts may also provide the health insurer with a range of financial protection less than full capitation (e.g., from discounted fee-for-service contracts to partial capitation and/or withholding funds from the provider that may only be paid after financial results have been evaluated against the provider contract agreement). The factors in Table 2 that vary by type of provider contract reflect this range of financial protection for the health insurer.

Table 2.

Category	Credit
Category 0—Arrangements not Included in Other	0%
Category 1—Contractual Fee Payments	15%
Category 2—Bonus / Withhold Arrangements	0-25%
Category 3—Capitation	60%
Category 4—Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements	75%

As Medicare Part D was implemented in 2006, the managed care credit was adapted to include a credit for stand-alone Part D plans in 2009 to reflect the reduction in risk to health plans attributable to the various risk adjustment programs implemented in accordance with the Affordable Care Act (ACA).

XR019 — Calculation of Category 2 Managed Care Factor

Category 2 in the managed care credit has a scaling factor determined by how significant the bonus / withhold payments are relative to the total claims subject to these programs. For example, if providers have been paid a 20% bonus on contracts subject to bonus, the managed care credit applicable is 20%.

3. Evolution in Underwriting Risk Since Original Development of the H2 Risk Factor

Changes in Health Care Economics and Provider Systems

There has been considerable evolution in health economics since HRBC was first developed in the 1990s. The most obvious is the significant rise in the size of the health care sector, which has grown by 6.8% annually over the last 25 years², amounting to nearly a fourfold increase over that period. As part of that growth, there have been major regulatory and industry changes as well.

Changes in Claims Distributions

Among the many changes brought about by the ACA, is the distribution of claim cost risk. For instance, the elimination of annual and lifetime coverage limits, the elimination of medical underwriting, and the establishment of essential health benefits, while addressing issues from a public policy standpoint, have contributed to higher frequencies of high-cost individual claimants (often referred to as catastrophic claims).

Additionally, there has been significant progress made in modern medicine, both from a medical/surgical and prescription drug standpoint. These advanced procedures and drugs often serve a niche market and can command very high prices. For example, gene therapies driving \$1

² Center for Medicare and Medicaid Services (CMS) National Health Expenditure Data.

million or higher price tags have become more common, and that trend is likely to continue moving forward.

Asymmetric Claims Risks

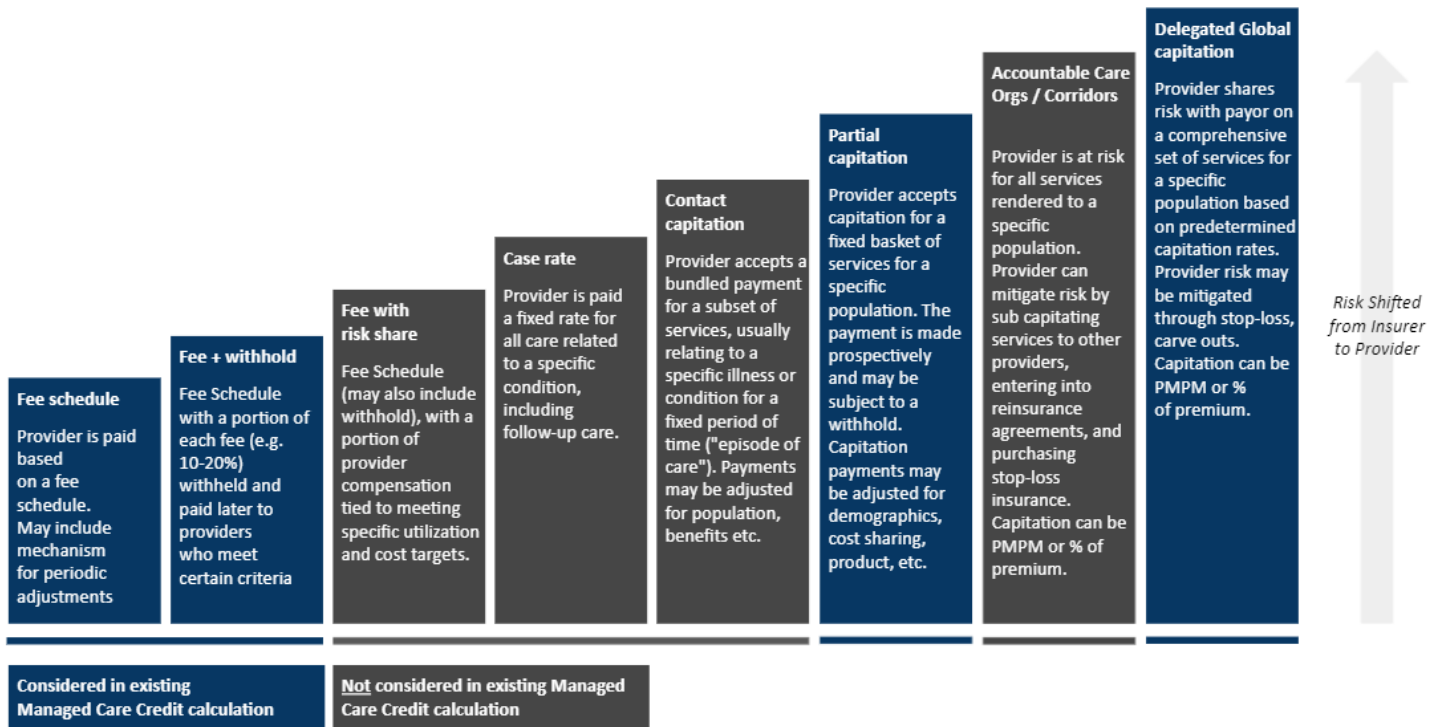
The profitability distribution for insurance carriers is often asymmetrical due to the introduction of minimum loss ratios and other risk sharing arrangements across many lines of business. In favorable years, carriers are required to rebate premiums to policy holders or government entities, while in unfavorable years they might have to absorb losses.

Provider Contracting Developments

The nature of insurer / provider relationships has also evolved significantly over the past 25 years. While fee-for-service payments are still common, there has been a significant increase in risk arrangements, particularly for government lines of business.

Insurance carriers have continued to move providers toward risk-based contracts as providers' risk tolerances have grown; frequently, this has led to improvement in member medical management and increasing insurer predictability of claims costs. Illustration 1 shows several new ways of contracting that are not currently contemplated in the formula.

Illustration 1.



Specific H2 Risk Considerations by Health Insurance Line of Business

Since the HRBC formula was developed, there have been significant changes in the lines of business that make up the health insurance industry. In addition to the introduction of the exchanges through the ACA, Medicare Advantage was implemented, and Medicaid Managed Care has become common for state Medicaid programs. Additionally, the LTC insurance market has changed materially as well.

Commercial Insured—Individual Market

The most significant event contributing to changes in underwriting risk in the individual market was the passage of the ACA in 2010 with the implementation largely phased in through calendar year 2014. Several changes affecting the individual health insurance underwriting risks include (not exhaustive):

- Elimination of annual and lifetime coverage limits
- Minimum medical loss ratio (MLR) requirement of 80%
- Pricing cycle requiring development and approval of rates well in advance of their implementation
- Increasingly robust rate review processes and provisions that influence the risk of adverse rate determinations and administrative actions (e.g., exchange exclusion)
- Elimination of pre-existing condition exclusions
- Revised and limited rating practices
- Risk mitigation programs (e.g., reinsurance, risk corridor, and risk adjustment mechanisms)

Commercial Insured—Small Group Market

Like the individual market, the commercial small group market was drastically altered by the ACA. Though similar changes were put in place (including the same minimum MLR requirement of 80%), it should be noted that usually the small group market is a separate risk pool from the individual market exhibiting its own risk characteristics.

Commercial Insured—Large Group Market and Self-Insured/Administrative Services

The ACA also affected commercial large group products, but to a lesser extent due to ERISA preemption of self-insured benefit programs. The minimum MLR requirement of 85% for large group insured coverage is somewhat more restrictive than the 80% minimums for individual and small group, reflective of the typically higher MLRs for large groups. Notably, there has been advancement in the type of medical insurance plans offered in the marketplace. At the time of original HRBC development, indemnity products were prevalent in the marketplace, with Health Maintenance Organization (HMO) plans offered by managed care organizations (MCOs). However, in the last 25 years, growth in preferred provider organizations (PPOs) and high-deductible health plans (HDHPs) have grown significantly. These products have different benefit

administration and provider payment characteristics than the indemnity products, which are far less prevalent today. For instance, per the Kaiser Family Foundation's 2021 Employer Health Benefits Survey,³ the proportion of covered workers enrolled in conventional (e.g., indemnity) health plans decreased from 26% in 1996 to ~1% in 2021. During that same period, enrollment in HDHPs, which were not tracked until 2006, has grown to 28%.

In addition, due to potential administrative cost savings of self-insured services and increases in employer risk appetite, there has been a shift from large group fully insured policies (loosely defined as groups with >100 employees) to self-insurance and analogs (e.g., minimum premium arrangements). From a payer underwriting risk perspective, this has reduced the proportion of claims expense and associated risk attributed to large employer groups. However, a corollary to this secular trend has been the growth in employer stop-loss products that hedge the claims risk to these clients.

Medicare

Since the creation of the original HRBC formula, four of the largest drivers of change impacting Medicare health insurer underwriting risk have been (1) the growth of the Medicare Population, (2) the creation of Medicare Part C with the Balanced Budget Act of 1997, (3) the creation of Part D prescription drug benefits and the modification of the Medicare Advantage managed care program with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and (4) Medicare provisions included in the ACA.

Under the Medicare Part C and Part D programs, beneficiaries can enroll for medical and/or prescription drug coverage under a private-sector payer. In return, the payer receives prospective, risk-adjusted capitation payments and member premiums. Under the ACA, payer capitation payments are tied to operational and clinical quality through the Star quality rating system, and a minimum medical loss ratio requirement of 85% was instituted, capping favorable payer surplus gains.

The net effect of these drivers has been an increase in Medicare spending, growth in the amount of Medicare underwriting risk borne by health payers, and increased complexity in the underwriting risk, due to the nature of risk adjustment, and quality and minimum loss ratio requirements. As a point of comparison, in 1998 under the prior Medicare HMO program, Medicare enrollment through private-sector plans was approximately 6 million.⁴ In 2020, approximately 24 million beneficiaries were served by Medicare Advantage. Medicare Advantage-share of enrollment had grown from 24% in 2010 to approximately 42% in 2021.⁵

³ <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf>

⁴ Squire, Daniel et al. *Group Insurance*, 7th Ed. Pg. 139.

⁵ [Medicare Advantage in 2021: Enrollment Update and Key Trends | KFF](#)

Medicaid and CHIP

Since the inception of the HRBC formula, there has been an overall expansion of the Medicaid program. In addition, there has been a shift to Medicaid Managed Care programs managed by private health payers, as opposed to state-based fee-for-service programs. Two drivers of change impacting health insurer underwriting risk have been (1) the enactment of Title XXI of the Social Security Act, which created the State Children's Health Insurance Program (CHIP), and (2) Medicaid enrollment expansions provided for in the ACA. As of 2019, 54.2% of all Medicaid expenditures were managed care and provider capitation payments.

Each state is unique in their requirements for Medicaid Managed Care products (i.e., risk adjustment protocols, minimum medical loss ratios, risk corridors, etc.). While a state is not required to establish a minimum medical loss ratio for Medicaid MCOs, CMS requires that (i) each contract calculate and report its medical loss ratio and (ii) for any state that does establish a minimum medical loss ratio, that the minimum may not be less than 85%.

Long-Term Care (LTC) Insurance

There are several characteristics of the LTC insurance market that have evolved since the product's inception that affect its underwriting risk profile.

When LTC insurance was initially developed, there was little to no applicable experience to use to price the product. As experience developed, the accuracy of the pricing has improved. This has led to three market segments: original (oldest generation) products that are the most underpriced, a middle generation with improved pricing, and a newer generation based on more credible experience leading to more appropriate pricing. The accuracy of the pricing, or lack thereof, impacts the level of rate increases being requested by the insurers, with the older blocks of business typically needing higher rate increases than the newer blocks.

With some exceptions, most insurers are managing closed blocks of business. There are challenges to managing the rates on closed blocks, particularly on the older and smaller blocks. On blocks that are smaller and older, even very large rate increases will generally have little to no impact to the financials of the insurer.

Large, actuarially justified rate increases are typically not being approved by the regulators, and in some cases, not being requested by insurers, due to concern for the impact on the consumer. This is a key difference between LTC insurance repricing and other health blocks. With other health blocks, there typically is not a large discrepancy between actuarially justified, requested, and approved rate increases, as is seen with LTC insurance. Also, because rate increases have been consistently occurring, there may be "rate-increase fatigue" on the part of regulators – leading to potentially fewer or less approvals of rate increases.

Other characteristics and developments in the LTC insurance market that affect the risk profile are the following:

- More credible data now exists for mortality and morbidity assumptions, used in rate increase and cash flow testing projections.
- The persistent low interest rate environment suppresses investment income.
- Possible increased litigation against insurers and reputational risk due to rate actions.
- Existence of LTC insurance hybrid products that have a different risk profile than stand-alone LTC insurance products.
- Actuarial Guideline (AG)-51—*The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves*.

These developments in the market affect the amount of risk that an insurer bears and may impact the fit-for-purpose of the current RBC H2 framework. Insurers will have different risk profiles that are dependent on the age of the business, the adequacy of rates, and the ability to receive future rate increases, none of which are fully addressed in the current framework.

4. Alternative Views of Underwriting Risk

There are a number of other capital evaluation/requirement frameworks that consider underwriting risk. Based on the subcommittee's review, several of these frameworks utilize risk quantification measures that would be valuable to consider as part of the health underwriting risk formula. The frameworks we found most instructive were Best's Capital Adequacy Relativity (BCAR), P&C RBC, Solvency II, and DMHC⁶ Tangible Net Equity (TNE) requirements.

BCAR

There are two main components of risk charges for underwriting risk within BCAR—net earned premium risk and reserve risk. The following summaries are based largely on descriptions of the BCAR methodology provided by AM Best.

Net Earned Premium Risk

The net premiums risk is related to risk of underwriting losses on a book of business written in the next year. AM Best created an industry database of profit and losses for each line of business, using each insurer's historical underwriting profit or loss based on the actual reported results. The industry database was then split based on the size of the net premiums written for that line of business, and statistical methods were applied to create distributions of profit and loss ratios.

The following blocks of business are evaluated separately:

⁶ California Department of Managed Health Care

Indiv Hosp Maj Med	Group Hosp Maj Med
Indiv Hosp Indem ADD	Group Hosp Indem ADD
Indiv Medicare Supp	Group FEHBP
Indiv Medicare Adv plus Choice	Group Dental
Indiv Medicaid	Group Vision
Indiv Medicare Part D	Group Disability - LTD
Indiv Medicare Part D Supp	Group Disability - STD
Indiv Fee for Service	Group Long Term Care
Indiv Disability - Non Can	Group Dread Disease
Indiv Disability - Other IDI	Group Stop Loss and Min Prem
Indiv Long Term Care	Group Lim Benefit
Indiv Dread Disease	Group Student
	Credit
	Group Prem Equiv ASO Stop Loss
	Workers' Comp Carve Out Prem
	All Other (Group&Indiv)

When calculating company-specific capital requirements, the industry factors can be adjusted based on the rating unit's own historical profitability. Implicitly, this assumes that historical underwriting performance is correlated with future underwriting performance. The company-specific factors are based on the most recent three years of profitability and can adjust the base factors by as much as 20% (positively or negatively). Like the H2 component of the health RBC formula, the rating unit's current year written premium is used in the model as a proxy for the premium to be written next year. Using this assumption, the company-specific factors are applied to current year premium to calculate the capital requirement.

Reserving Risk

Unlike health RBC, BCAR includes a reserving risk component as part of underwriting risk. The applied risk charges are intended to cover the possibility of negative reserve development due to adverse claims experience. Like premium risk, AM Best's reserve risk factors are based on an industry database of each company's reserve adequacy generated from the annual statements by line of business and a company's specific experience can adjust the base factor by as much as 20%. The BCAR formula utilizes the following reporting segments to develop reserving risk factors.

Group A&H	Workers Comp Carve-Out Liability
Credit A&H	Comprehensive
Collectively Renewable	Medicare Supplement
Non-Cancellable	Dental
Guaranteed Renewable	Vision
Non-Renewable	Fed Employees
Other Accident	Title XVIII Medicare
All Other	Title XIX Medicaid
	Other Health

Diversification Credit

AM Best calculates diversification factors using correlation matrices based on industry-aggregated data across lines of business—for both premium risk and reserving risk. This intent behind the calculation is that often underwriting profits and losses in one line of business might offset underwriting profits and losses in another line of business. Similar to written premium, because reserves are largely set based on line of business, adverse or favorable reserve development for one line of business might offset development for another line of business.

Managed Care Credit

The managed care credit within the BCAR formula reflects the reduction in the overall premium risk charge for companies with managed care arrangements that reduce uncertainty regarding future claim payments.

This credit is reduced for the risk that the MCO will pay the capitation to a provider but not receive the agreed-upon services and will encounter unexpected expenses in arranging for alternative coverage, essentially introducing a credit risk that a provider might default on its obligations. This credit risk charge is based on the contractual relationship between the MCO and a provider. Higher credit risk charges apply to capitation payments made to unaffiliated or third-party care providers than to capitation payments made to affiliated care providers.

P&C RBC

Similar to BCAR, P&C underwriting risk is broken into two components in the P&C RBC formula: reserves and net written premiums.

Reserve Risk

The reserve risk RBC is developed by multiplying a set of RBC factors, which are discounted for investment income and adjusted for each individual company's own relative experience of its net reserves for each line of business. The reserve risk is also adjusted downward with a credit for diversification among the lines of business.

The major lines of business largely correspond to the breakdowns in the annual statement (e.g., the Underwriting and Investment Exhibit). Calculations for some, generally smaller, lines are combined.

Net Written Premium

The net written premium component is developed by multiplying a risk factor (based on an analysis historical industry-wide underwriting performance at the 87.5th percentile) by the current year's net written premiums, by line of business. The actual risk charge is based on the excess of a discounted combined ratio adjusted for investment income over 100%. As with the reserve risk factors, individual company experience is also considered in computing the RBC factor.

Solvency II

Solvency II divides health insurance into Similar to Life Techniques (SLT) and Non-Similar to Life Techniques (Non-SLT)—the distinction based on how products are priced. Products like long-term care insurance and individual disability income insurance would likely be examples of SLT Health, while typical medical products would be examples of Non-SLT Health.

The nature of how the Solvency II capital requirement is constructed is very different between SLT Health and Non-SLT Health. Solvency II discusses three main risks for Non-SLT Health:

1. Premium Risk
2. Reserve Risk
3. Catastrophe (CAT) risk

The time horizon for Solvency II is one year. In keeping with that, the definition of premium risk relates to both unexpired risks on existing contracts and policies to be written/renewed during the coming year. As a result, the inputs into the Solvency II calculation are prospective in nature, rather than retrospective in nature like current HRBC. The issuer is expected to estimate not just its expected premiums for the coming year from the unexpired term on existing contracts, but also its expected premiums for the coming year on both new and renewal business. Keeping with the one-year time horizon, the focus is on the risk of loss within the coming year and not on the risk of cumulative losses over a longer time frame.

DMHC Tangible Net Equity (TNE)

The DMHC⁷ maintains a simple capital requirement driven by underwriting risk. Full-service health plans must maintain a TNE of at least:

- (1) \$1 million; or
- (2) the sum of two percent (2%) of the first \$150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of \$150 million; or
- (3) an amount equal to the sum of:
 - (A) eight percent (8%) of the first \$150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus
 - (B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of \$150 million; plus
 - (C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

This approach of excluding capitated payments demonstrates one potential approach for the managed care credit. It is worth noting that risk-bearing organizations (i.e., those that accept capitation) are regulated by the DMHC and themselves must meet minimum capital requirements, and requirements for risk-bearing organizations vary considerably from state-to-state.

⁷ Cal. Code Regs. Title 28, §1300.76 - Plan Tangible Net Equity Requirement.

5. Options for Better Aligning H2 Risk Factors to Economic Risk

Based on the subcommittee's review of the current H2 risk factors, the evolution of health insurance underwriting risk since those risk factors were originally contemplated, and the alternative approaches utilized by other regulating entities, we recommend further study and potential implementation of, the following changes to the H2 underwriting risk factors.

1. Refresh factors based on updated insurer data
2. Develop factors at a more granular product level
3. Develop factors specific to more relevant block sizes and consider an indexing factor for cut points to change over time
4. Model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly
5. Refresh of managed care credit formula and factors to be more relevant and reflective of common contracting approaches and other risk factors associated with these contracting approaches
6. Analyze long-term care insurance underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time

Refresh factors based on updated insurer data

Because the underwriting risks taken by health insurers has changed significantly since many of the H2 underwriting risk factors were adopted, we recommend utilizing updated data to understand the current risk profile of health insurers. This could be achieved utilizing underwriting performance and volatility over the past 10 years—between 2011 and 2020—to consider pre-ACA, post-ACA and pandemic years to create new risk factors.

Develop factors at a more granular product level

Because many health products carry a range of underwriting risk—even within comprehensive medical coverage—a more detailed product view can be utilized to create new risk factors. For example, Commercial Group and Individual products are currently both included within the Comprehensive Medical column but have significantly different levels of volatility and associated financial risk.

This recommendation could be accomplished in the immediate term by utilizing reporting data from Page 7—Analysis of Operations by Line of Business. Over time, factors should be developed even more granularly. This can be accomplished by utilizing the Accident and Health Policy Experience Exhibit but would either require a change to when that filing would be submitted or via company records within the RBC filing.

Develop factors specific to more relevant block sizes and consider an indexing factor for cut points to change over time

As blocks grow, underlying volatility declines given the law of large numbers, but the relevant cut points to reflect that decline in volatility are likely well above what is currently utilized within the Underwriting Risk formula (e.g., \$3M, \$25M). Given the high prevalence of claimants

reaching costs well in excess of anything contemplated 20 years ago, these cut points should be revised to reflect more relevant block sizes and shifts in volatility.

Model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly

Because risk factors are applied to historical claims to calculate capital buffers for losses against future premiums, the updated risk factor analysis should analyze prospective future losses over a defined time horizon. There are a range of defensible time horizons and safety levels that could be utilized within the risk factor modeling. While a one-year time horizon is most common, multiyear horizons could arguably better reflect the underwriting cycle. A range of safety levels could also be reasonably justified. Ultimately, these two modeling elements require regulatory discretion but should be well-defined and generally consistent over time to enable business management.

Refresh of managed care credit formula and factors to be more relevant and reflective of common contracting approaches and other risk factors associated with these contracting approaches

Because many of the common provider contracting mechanisms that existed when the factors were originally created are no longer widely used, an update to the managed care credit would better account for approaches like gain sharing and bundled payments. Additionally, the subcommittee encourage revisiting the bonus calculation for Category 2 claims in light of typical bonus levels available to providers and whether those bonuses have reduced underwriting volatility for health plans.

Analyze long-term care insurance underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time

Because the underwriting environment for LTC insurance policies has undergone multiple somewhat discrete phases, it would likely be appropriate to evaluate LTC insurance underwriting risk charges according to the groups of policy issue years (e.g., before 2000, between 2000 and 2010, after 2010).

6. Potential Next Steps for Working Group Consideration

As a next step, the Subcommittee recommends first focusing on developing new factors on XR013 and XR018/XR019 consistent with recommendations 1 - 6 above. This would involve collecting historical statutory financial data from the analysis of operations by lines of business as well as Exhibit 7 Part 1—Summary of Transactions with Providers. Then, a data analysis exercise would be required to develop risk factors at a range of safety levels for the working group's consideration.

Following that analysis, other underwriting risk factors (e.g., those on XR015 and XR016) could be evaluated utilizing the working group-approved approach—likely with special consideration for LTC insurance.

Thank you for the opportunity to provide this report in response to the request of the working group to provide analysis to perform a comprehensive review of the H2—Underwriting Risk component and the managed care credit calculation within the health RBC formula. We welcome the opportunity to speak with you in more detail and answer any questions you might have regarding this report. If you would like to discuss anything pertaining to this report and its recommendations, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org to make arrangements.

Sincerely,

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

CC: Crystal Brown
Senior Insurance Reporting Analyst
cbrown@naic.org

MEMORANDUM

TO: Thomas Botsko (OH)
Chair of the Property Casualty Risk-Based Capital (E) Working Group

FROM: David Smith & Doug Stolte (VA)
Co-Chairs of the Restructuring Mechanisms (E) Subgroup

DATE: January 29, 2020

RE: Request for Input

The Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group and Restructuring Mechanisms (E) Subgroup in early 2019. The Subgroup has determined that its priority in addressing its charges is to develop best practices as it relates to reviewing and considering such transactions for approval. While the Subgroup intends to leverage existing practices used by international regulators and other practices proposed in the past for liability-based restructuring, addressing this priority charge is expected to take some time. Among other things, the Subgroup is also charged with the following:

Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. Complete by the 2020 Fall National Meeting.

In order to be responsive to the RBC charge noted above, the Subgroup requests your Working Group to take the lead in addressing this charge. More specifically, as the subject matter experts of the Property Casualty RBC formula, you are best equipped to determine if changes should be made to the formula to better assess companies in runoff. As the issues and positions are identified, we ask that P&C RBC also to take the lead in coordinating with other RBC working groups including Life and Health.

We note that the above charge is for companies in run-off rather than for blocks of business only in run-off. The subgroup's survey of states asked questions regarding the definition of run-off. These responses are shared with the Working Group on the following page for discussion.

As noted above, our charge has a due date of the 2020 Fall National Meeting; therefore to the extent you are unable to come to a conclusion prior to that date, please notify us and include in such a notification a more appropriate date under which you could make such a determination. From there, the Subgroup will request an extension based upon your suggestion.

Please contact me or NAIC staff for this project, Robin Marcotte rmarcotte@naic.org, if you have any questions.

Cc: Dan Daveline, Eva Yeung; Jane Barr

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1. Does your state have a definition for “Runoff Companies”?

- a. Yes – 4 states
- b. No – 29 states however, 4 provided responses.

State ¹	Response
1.	Yes (none was provided). Comment in RBC it discusses running off or run off but not definition.
2.	Yes. There is no formal definition. It is understood to mean companies that, voluntary or not, have ceased writing premium except for mandatory renewals required by regulation in various states.
3.	Yes. Licensed companies that are no longer writing business and have no plans to write in the future.
4.	Yes. Under the state’s laws "Run-off insurer" means an insurer that: (i) Is domiciled in the state; (ii) Has liabilities under policies for property and casualty lines of business; (iii) Has ceased underwriting new business; and (iv) Is only renewing ongoing business to the extent required by law or by contract. However, for purposes of the Restructuring Mechanism Subgroup, we believe the following definition is appropriate to define "Runoff Companies" in general: "Companies that are no longer actively writing new insurance business or collecting premiums except where required to in accordance with contractual or regulatory obligations, and whose sole material business is the management of an existing or assumed group of insurance policies or contracts through their termination."
5.	No. However, in practice, a run-off company services only existing business, does not write new business, and has no intent to acquire or engage in the business of run-off by acquiring other run-off blocks of business
6.	No. The state’s insurance law does not define “runoff companies;” however, the state applies a general concept of “runoff companies” to include an insurer that writes no new premium or has had no new policyholders for several years leading to claims administration only.
7.	No. This concept is something we plan to institute internally in 2019. The details have yet to be determined.
8.	No. There is no formal definition for "Runoff Companies" in the statutes or regulations.

¹ State numbers are just for the responses and state 1 in a chart may be a different state in the next chart.

**NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS****MEMORANDUM**

TO: David Smith (VA) and Doug Stolte (VA), Co-Chairs of the Restructuring Mechanisms (E) Subgroup
Judith L. French (OH), Chair of the Capital Adequacy (E) Task Force

FROM: Tom Botsko (OH), Chair of the Property and Casualty Risk-Based Capital (E) Working Group

DATE: Oct. 25, 2021

RE: Response to Request for Input Regarding Runoff Companies

The Property and Casualty Risk-Based Capital (E) Working Group formed a small ad hoc group to discuss this topic and try to determine the best course of action. The Restructuring Mechanisms (E) Subgroup requested that the Working Group take the lead in addressing the charge to “consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. “

After several discussions about what adjustments should be made to the risk-based capital (RBC) formula, the ad hoc group concluded that the best course of action is to monitor these companies through the state analysis and exam team functions. The characteristics and financial conditions of these runoff companies are very diverse, and it would be difficult to incorporate these varied characteristics into one adjusted formula. Many international countries monitor these companies through the analysis and exam processes and do not have a separate RBC formula.

Of the 2020 RBC filers, we identified 111 companies out of 2,477 that have the characteristics of a runoff company. Most of these companies have an RBC ratio greater than 300%. Five are below 200%.

During a series of discussions, the ad hoc group agreed that a runoff company, voluntary or involuntary, should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no new direct or new assumed business; and 3) no additional runoff blocks of business. In addition, the amount of renewal premium to reserves has also been identified as a characteristic of these types of companies when this ratio is de minimis.

The ad hoc group also recommends that a general and RBC interrogatory be added for the purpose of identifying a runoff company. The domiciliary state shall have the ability to verify the interrogatory response during the annual company financial analysis process.

As the ad hoc group considered various types and conditions of runoff companies, it became apparent that while many of these companies share the characteristic of very long tail liabilities, there are other characteristics of these companies that are so diverse that it made it difficult to summarize them into their own RBC formula.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The ad hoc group reviewed several international perspectives of runoff companies. The international treatment of runoff companies is handled through the Analysis and Exam Teams. The ad hoc group agrees that a similar treatment of runoff companies is warranted.

The ad hoc group has some recommendations for the Working Group regarding the RBC instructions, specifically to the runoff companies. These include the following:

- Remove the Trend Test from the RBC calculation. These are runoff companies, and the possible retrospective premium should not complicate the already diverse situation.
- Remove the charge for premium growth if the company is no longer writing business.
- Remove R_{cat} from the formula. Because one of the characteristics of a runoff company is to not have written any new business for at least 12 months, we believe this short-term liability risk is not warranted.

As the ad hoc group shares its findings with the other two RBC working groups, we expect to hear other perspectives regarding the unique conditions of runoff companies from the Life Risk-Based Capital (E) Working Group and the Health Risk-Based Capital (E) Working Group.

Please contact Eva Yeung, NAIC staff support for the Property and Casualty Risk-Based Capital (E) Working Group, at eyeung@naic.org with any questions.

Cc: Robin Marcotte; Dan Daveline; Jane Barr; Eva Yeung