NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 12/14/21

Virtual Meeting

HEALTH RISKED-BASED CAPITAL (E) WORKING GROUP
Thursday, December 16, 2021
2:00 – 3:00 p.m. ET / 1:00 – 2:00 p.m. CT / 12:00 – 1:00 p.m. MT / 11:00 a.m. – 12:00 p.m. PT

ROLL CALL

Steve Drutz, Chair	Washington	Michael Muldoon	Nebraska
Jennifer Li	Alabama	Tom Dudek	New York
Wanchin Chou	Connecticut	Kimberly Rankin	Pennsylvania
Carolyn Morgan/Kyle Collins	Florida	Mike Boerner/Aaron Hodges	Texas
Tish Becker	Kansas		

NAIC Support Staff: Crystal Brown

AGENDA

1. Discuss Comments Received on Proposal 2021-18-H—*Steve Drutz (WA)* — Attachment One
   - UnitedHealth Group (UHG) Comment Letter—Jim Braue (UHG) — Attachment Two
2. Consider Exposure of a Health Test Language Proposal—*Steve Drutz (WA)* — Attachment Three
3. Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*
4. Adjournment

Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE:	**10/25/2021**
CONTACT PERSON:	**Crystal Brown**
TELEPHONE:	**816-783-8146**
EMAIL ADDRESS:	**cbrown@naic.org**
ON BEHALF OF:	**Health RBC (E) Working Group**
NAME:	**Steve Drutz**
TITLE:	**Chief Financial Analyst/Chair**
AFFILIATION:	**WA Office of Insurance Commissioner**
ADDRESS:	**5000 Capitol Blvd SE**
	Tumwater, WA 98501

FOR NAIC USE ONLY

Agenda Item # 2021-18-H
Year 2022

DISPOSITION

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

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

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

DESCRIPTION OF CHANGE(S)

Incorporate benchmarking guidelines for the Working Group to follow in updating the investment income adjustment in the underwriting risk factors for Comprehensive Medical, Medicare Supplement and Dental & Vision.

REASON OR JUSTIFICATION FOR CHANGE **

The reason for the change is to clearly identify the frequency and parameters to use in adjusting the underwriting risk factors for investment income in the Comprehensive Medical, Medicare Supplement and Dental & Vision lines.

Additional Staff Comments:

**** This section must be completed on all forms.** **Revised 11-2013**

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

Detail Eliminated to Conserve Space

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	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, 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. The Working Group will evaluate the yield of the 6-month Treasury bond as of January 1st each year and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

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

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UNITEDHEALTH GROUP

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

November 30, 2021

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

Via electronic mail to Crystal Brown.

Re: Proposal 2021-18-H.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group in regard to Proposal 2021-18-H, as exposed for comment on 11/4/21. As we have stated in previous comment letters, we are supportive of investment income being reflected in the Health Risk-Based Capital formula, and we appreciate the work that your Working Group has done to implement that concept.

Proposal 2021-18-H bases the investment income adjustment on "the yield of the 6-month Treasury bond as of January 1st each year." We will comment on two aspects of this proposal: the 6-month maturity assumption and the January 1 reference period.

Six-month maturity assumption.

As explained in our comment letters of 1/6/21 and 4/16/21, we believe that a longer maturity assumption than 6 months is warranted. In particular, we have suggested that a 5-year maturity assumption would be reasonable, given that the bond risk factors were based on an assumed 5-year maturity. The same portfolio that generates the bond risk is also generating the investment income that is being reflected in the underwriting risk factors.

Two objections have been raised to using a 5-year maturity: a concern about asset/liability mismatch; and a concern about consistency with premium rate filings. We will address both concerns below.

1. Asset/liability mismatch.

Considerable emphasis has been placed on the fact that most claims are paid within a few months of when they were incurred. The analysis that the American Academy of Actuaries

performed to determine the investment income adjustment indicated that the average lag until payment for a comprehensive medical claim is less than two months. However, as we noted in our 1/6/21 letter, the run-out period of a single incurral date's claims is not really relevant from an investment standpoint. As a going concern, a health entity does not repeatedly run its assets down to zero as claims are paid; there is a continual inflow of cash from premiums and other revenues, and investments are held for a longer term. Generally speaking, investment maturities would not be needed for as long as the entity's business is stable or growing, except in cases where cash outflows exceeded cash inflows because of abnormally high levels of claims or other expenses.

Over what period might we assume that an entity's volume of business will remain stable? For purposes related to the underwriting risk charges, we can look at what the Academy assumed in developing those charges. In the December 1994 report (as revised) of the Academy's Health Organizations Risk Based Capital Task Force to the NAIC's Health Organizations Risk-Based Capital Working Group, the Academy explained the following about the model used in determining the underwriting risk charges:

> The purpose of this model is to simulate the financial results of a block of business over a five year period. … The block of business that is simulated is assumed to represent a stationary population. This means that as old business lapses, new business is written, and the characteristics of the inforce remains steady over time.

This, by itself, would suggest that a five-year investment maturity is indeed consistent with the assumptions underlying the development of the underwriting risk factors. It might be legitimately objected that, while the Academy may have evaluated risk assuming five years of steady volume, the modeled entity would not necessarily have made that same assumption in its investment strategy. That is true, but likewise the entity would not necessarily assume the imminent termination of all of its business. The use of a six-month maturity assumption could mean, as an example, that the entity expected more than 50% of its business to be terminated immediately, and the remainder to be terminated in one year. (The percentage is "more than" 50% because the run-off of the claims would add, as noted above, something more than a month to the average maturity.) While some entities, with concerns about the stability of their business, might make such an assumption, it does not seem like a reasonable assumption for the broad majority of entities covered by the Health RBC formula.

During a previous discussion, one regulator pointed out that, while immediate termination of most or all of an entity's business might not be a reasonable assumption, in some markets a 30% termination rate would be quite reasonable. Consider that, if 30% of an entity's business terminated immediately (net to any new business added), and another 30% of the remaining business terminated at the beginning of each subsequent year, on average the business would be on the books for about 2.3 years. If we wanted to be more conservative than to assume that the 30% annual termination continued indefinitely, and instead assumed that all remaining business would terminate at the end of the third year, the average life of the business would still be more than 1.5 years. Because that number represents an average, and because the yield curve is currently convex upwards, the resulting interest rate might

correspond to a maturity somewhat less than 1.5 years, but still more than one year. To reduce that rate further, to represent a six-month maturity, seems overly conservative.

Another potential objection is that the RBC formula does in fact assume that there will be losses, and that therefore cash outflows might indeed be assumed to exceed cash inflows, resulting in a need for shorter maturities. However, two things should be considered: first, that the underwriting risk charges (approximating the excess outflows) will in most cases be less than the claim reserves; and second, that the underwriting risk charges represent a cumulative loss over five years, which would not necessarily all need to be funded in the first year or two. Therefore, the capital that covers the excess outflows would not necessarily be invested to a shorter horizon than the claim reserves themselves, and accordingly would not significantly impact the average maturity of the investment portfolio.

In summary, even rather conservative assumptions about business volume would lead to an assumed maturity in the range of one to two years. Less conservative assumptions could easily justify a maturity above two years, since, for example, an entity experiencing a 30% loss of business might adjust its pricing and/or marketing to reduce further losses, rather than allow the 30% to continue or worsen.

2. Consistency with premium rate filings.

Regulators have raised the concern that the assumption of any non-trivial amount of investment income would be inconsistent with the assumptions that they have seen in premium rate filings, where, they state, investment income is typically dismissed as being immaterial. First, we must note that there may legitimately be differences between what is assumed for RBC purposes and what is assumed for rate filings, because of, for instance, differing standards of materiality.

However, even if we suppose that the same assumption should be used for both purposes, it does not follow that the rate filings should be driving the RBC outcome. RBC should be based on the best available data and reasoning. If those data and rationales seem at odds with what is being assumed elsewhere, it is those other assumptions that should be considered suspect.

Further, we point out that the RBC formula is applied to a broad population of health entities, whereas rate filings are entity-specific. If a regulator is concerned about whether an entity has appropriately reflected investment income in its rate filing, that entity can be required to provide further justification for its assumptions. RBC, on the other hand, must be appropriate for a wide variety of circumstances, and there is a practical limitation on how much it can be tailored to individual entities.

In summary, it does not seem appropriate to base RBC assumptions on what is depicted in premium rate filings.

We recognize that the proposal to round the investment income rate up to the next higher multiple of 0.5% was intended, at least in part, to effectively lengthen the maturity assumption.

However, while a fix of that sort might produce a reasonable result at a given point in time, it is unlikely to work properly in the long term. When the yield curve has a steep positive slope, the adjustment will be inadequate. When the yield curve is flat or, especially, inverted, the adjustment will be excessive. To avoid such outcomes, the maturity assumption should be set appropriately, and a lesser degree of rounding should be used.

In regard to that rounding convention, we will also note that the proposal states, "Any adjustments will be rounded up to the nearest 0.5%." We suggest that, to avoid confusion, the sentence should begin, "The investment income yield will be rounded …" The word "adjustment" might be construed to mean the change in the underwriting risk factor, rather than the yield assumption underlying that change.

January 1 reference period.

Proposal 2021-18-H provides, "The Working Group will evaluate the yield of the 6-month Treasury bond as of January 1st each year …" We have some concerns regarding the phrase "as of January 1st." To begin with, the fixed income markets typically will not be open on January 1, and many rate sources (e.g., the U.S Treasury department's Daily Treasury Yield Curve Rates) will not supply a value for that date, leaving open to question what value should be used. More importantly, it may be inadvisable to use any single date as the basis for the yield determination, because the rate on a single date may be anomalous, e.g., because of overreactions to certain news items. It would be better to use the average yield over a somewhat longer period, such as the first ten business days of the year, or even the first month of the year. This would tend to minimize the impact of any one anomalous rate, while still allowing the determination to be made early in the calendar year.

* * * * *

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

James R. Braue

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Crystal Brown, NAIC
Randi Reichel, UnitedHealth Group

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

	DATE: 11-3-21	**FOR NAIC USE ONLY** Agenda Item # _____ Year 2022 Changes to Existing Reporting [ ] New Reporting Requirement [ ]
CONTACT PERSON:	Crystal Brown	**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT** No Impact [ ] Modifies Required Disclosure [ ]
TELEPHONE:	816-783-8146	**DISPOSITION** [ ] Rejected For Public Comment [ ] Referred To Another NAIC Group [ ] Received For Public Comment [ ] Adopted Date _____ [ ] Rejected Date _____ [ ] Deferred Date _____ [ ] Other (Specify) _____
EMAIL ADDRESS:	cbrown@naic.org	
ON BEHALF OF:	Health Risk-Based Capital (E) WG	
NAME:	Steve Drutz	
TITLE:	Chair	
AFFILIATION:	WA Office of the Insurance Commissioner	
ADDRESS:		

BLANK(S) TO WHICH PROPOSAL APPLIES

[ ] **ANNUAL STATEMENT**	[x] **INSTRUCTIONS**	[ ] **CROSSCHECKS**
[ ] **QUARTERLY STATEMENT**	[ ] **BLANK**	
[x] Life, Accident & Health/Fraternal	[ ] Separate Accounts	[ ] Title
[x] Property/Casualty	[ ] Protected Cell	[ ] Other _____
[x] Health	[ ] Health (Life Supplement)	

Anticipated Effective Date: _____

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Annual Statement Test language

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the change is to move those filers who write predominantly health business and file on the life blank to begin filing on the health blank.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:
The Health Test Ad Hoc Group of the Health Risk-Based Capital (E) Working Group continues to discuss and review any potential modifications to premium and reserve ratios. The group will continue to evaluate if there should be changes and if so, will propose this to the Blanks (E) Working Group in a separate proposal for consideration in future years.

The references to the Life & Property & Casualty General Interrogatories were changed from pulling from RBC to instead pull from the Analysis of Operations By Lines of Business – Accident and Health and Underwriting & Investment Exhibit, Part 1B, respectively. The life General Interrogatory references will be further updated if proposal 2021-17BWG is adopted.

**** This section must be completed on all forms.** **Revised 7/18/2018**

Health

GENERAL

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**

   If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

   Passing the Test:

   A reporting entity is deemed to have passed the Health Statement Test if the values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

   Failing the Test:

   If a reporting entity, licensed as a life, accident and health or property and casualty insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it will revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of the second year following the reporting year. If a reporting entity, licensed as a health insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it should continue to file the health annual statement.

   Variances from following these instructions:

   If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

General Interrogatories

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

   All reporting entities should file the test.

   Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	Health Premium values listed in the Analysis of Operations by Line of Business ~~(Gain and Loss Exhibit)~~, Line 1, Column 1 through Column 9 (in part for credit A&H and dread disease coverage, LTC, Disability Income), Column 10 of the reporting year's annual statement.	Health Premium values listed in the Analysis of Operations by Line of Business ~~(Gain and Loss Exhibit)~~, Line 1, Column 1 through Column 9 (in part for credit A&H and dread disease coverage, LTC, Disability Income) Column 10 of the reporting year's annual statement.
2.2	Premium Denominator	Net Premium Income~~Premium and Annuity Considerations~~ (Page 4, Line 2, Column 2) of the reporting year's annual statement.	~~Premium and Annuity Considerations~~Net Premium Income (Page 4, Line 2, Column 2) of the prior year's annual statement.
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4 (a)	Reserve Numerator	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H + Part 2D (Line 8, Column 1 minus Column 9) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc. of the reporting year's annual statement.	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H + Part 2D (Line 8, Column 1 minus Column 9) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc. of the reporting year's annual statement.
2.5	Reserve Denominator	Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the reporting year's annual statement.	Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the prior year's annual statement.
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

(a) Alternative Reserve Numerator – Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

Life, Accident and Health /Fraternal

Health Test

GENERAL

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**

   If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

   Passing the Test:

   A reporting entity is deemed to have passed the Health Statement Test if:

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The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

~~AND~~

~~The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.~~

~~AND~~

~~At least seventy-five percent (75%) of the entity's current year premiums are written in its domiciliary state~~.

~~OR~~

~~The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.~~

If a reporting entity is a) licensed as a life and health insurer; b) completes the Life, Accident and Health annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end.

Variances from following these instructions:

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

General Interrogatories

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

   All reporting entities should file the test.

   Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	**Health Premium** values listed in the~~the~~ Analysis of Operations By Lines of Business – Accident and Health: ~~statement value column (Column 1) of the reporting year's Life RBC report~~: ~~Individual Lines:~~ ~~Usual and Customary Major Medical and Hospital~~Comprehensive (Individual & Group) – (Columns 1 & 2, Line 1) Medicare Supplement (Column 4, Line 1) Medicare Part D (Column 13 (in part), Line 1) Dental and Vision (Columns 5 & 6, Line 1) Medicare (Column 8, Line 1) Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Column 9, Line 1) ~~Group Lines:~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ Stop Loss and Minimum Premium (Column 13 (in part), Line 1) ~~Dental and Vision~~ Federal Employee Health and Benefit Plan (Column 7, Line 1)	**Health Premium** values listed in the ~~statement value column (Column 1) of the reporting year's Life RBC report~~Analysis of Operations By Lines of Business – Accident and Health: ~~Individual Lines:~~ Comprehensive (Individual & Group) –(Columns 1 & 2, Line 1)~~Usual and Customary Major Medical and Hospital~~ Medicare Supplement (Column 4, Line 1) Medicare Part D (Column 13 (in part), Line 1) Dental and Vision (Columns 5 & 6, Line 1) Medicare (Column 8, Line 1) Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Column 9, Line 1) ~~Group Lines:~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ Stop Loss and Minimum Premium (Column 13 (in part), Line 1) ~~Dental and Vision~~ Federal Employee Health and Benefit Plan (Column 7, Line 1)
2.2	Premium Denominator	Premium and Annuity Considerations (Page 4, Line 1) of the reporting year's annual statement	Premium and Annuity Considerations (Page 4, Line 1) of the prior year's annual statement

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2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4(a)	Reserve Numerator	Net A&H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Column 10) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)	Net A&H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Column 3) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)
2.5	Reserve Denominator	Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)	Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

Property/Casualty

Health Test

GENERAL

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**

   If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

   Passing the Test:

   A reporting entity is deemed to have passed the Health Statement Test if:

   The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

   ~~AND~~

   ~~The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.~~

   ~~AND~~

   ~~At least seventy-five percent (75%) of the entity's current year premiums are written in its domiciliary state.~~

   ~~OR~~

   ~~The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.~~

   If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end.

   Variances from following these instructions:

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If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

General Interrogatories

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

   All reporting entities should file the test.

   Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	**Health Premium** values listed in the ~~statement value~~ Net Premiums Written column (Column ~~1~~4) of the reporting year's ~~P&C RBC report~~U&I Part 1B: Individual Lines: ~~Usual and Customary Major Medical and Hospital~~Comprehensive (hospital and medical) (individual and group) (Lines 13.1 and 13.2) Medicare Supplement (Line 15.4) Medicare Part D (Line 15.9, in part) Dental and Vision (Lines 15.1 and 15.2) Medicare (Line 15.6) Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Line 15.5) ~~Group Lines:~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ Stop Loss and Minimum Premium (Line 15.9, in part) ~~Dental and Vision~~ Federal Employee Health and Benefit Plan (Line 15.8)	**Health Premium** values as listed in the statement value column (Column 1) of the prior year's P&C RBC report: Individual Lines Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision Group Lines Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Stop Loss and Minimum Premium Dental and Vision Federal Employee Health and Benefit Plan
2.2	Premium Denominator	Premiums Earned (Page 4, Line 1) of the reporting year's annual statement	Premium Earned (Page 4, Line 1) of the prior year's annual statement
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4(a)	Reserve Numerator	Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15) of the reporting year's annual statement.	Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15) of the prior year's annual statement.
2.5	Reserve Denominator	Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the reporting year's annual statement.	Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year's annual statement.
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

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