



# NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 4/15/21

*Virtual Meeting*

## HEALTH-RISKED BASED CAPITAL (E) WORKING GROUP

Friday, April 23, 2021

12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

### ROLL CALL

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

NAIC Support Staff: Crystal Brown

### AGENDA

1. Consider Adoption of its Mar. 17, 2021, Minutes—*Steve Drutz (WA)* Attachment A
2. Discuss 20 Designation Bond Factors—*Steve Drutz (WA)*
  - Summary of Two- and Five-Year Time Horizon Bond Factor Impact Analysis Attachment B
  - Consider Exposure of Proposal 2021-09-H Attachment C
3. Discuss the Investment Income Adjustment to the Underwriting Risk Factors (Proposal 2021-04-CA)—*Steve Drutz (WA)* Attachment D
  - Receive Comments on 2021-04-CA
    - UnitedHealth Group—*Jim Braue* Attachment E
    - America’s Health Insurance Plans and BlueCross BlueShield Association—*Ray Nelson (AHIP) and Carl Labus (BCBSA)* Attachment F
  - Consider Referral to the Capital Adequacy (E) Task Force for Exposure for all Lines of Business
4. Discuss a Comprehensive Review of the H2 Underwriting Risk Component Including Managed Care Credit—*Steve Drutz (WA)*
  - Health Risk-Based Capital Working Agenda Attachment G
  - Consider Request to the American Academy of Actuaries to Review
5. Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*
6. Adjournment

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Draft: 3/22/21

Health Risk-Based Capital (E) Working Group  
Virtual Meeting (*in lieu of meeting at the 2021 Spring National Meeting*)  
March 17, 2021

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Mar. 17, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Jennifer Li (AL); Wanchin Chou (CT); Carolyn Morgan (FL); Tish Becker (KS); Rhonda Ahrens (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges (TX).

1. Adopted its Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020 Minutes

The Working Group met Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020. During these meetings, the Working Group took the following action: 1) received, exposed and discussed the American Academy of Actuaries (Academy) report on the inclusion of investment income in the underwriting risk component and impact analysis; 2) discussed its March 5 regulator-to-regulator meeting; 3) referred the health care receivable proposal to the Blanks (E) Working Group for consideration in 2021 reporting; 4) exposed proposal 2021-02-CA (Managed Care Credit – Incentives); 4) received an update on the bond factor analysis; and 5) received a summary of the Blanks (E) Working Group’s proposal related to health business reporting and discussed next steps for the Health Test Ad Hoc Group.

Mr. Chou made a motion, seconded by Mr. Dudek, to adopt the Working Group’s Feb. 10, 2021; Jan. 22, 2021; and Dec. 18, 2020 minutes (Attachment **Two-A**). The motion passed unanimously.

2. Adopted its 2021 Working Agenda

Mr. Drutz summarized the changes to the 2021 health risk-based capital (RBC) working agenda, which included the following substantial changes: 1) the addition to review the managed care credit across the formulas; 2) the deletion of the MAX function as the proposal was adopted for 2021 reporting; and 3) moving the investment income and bond factor items from the New Items section to the Carry Over Items section.

Mr. Chou made a motion, seconded by Ms. Rankin, to adopt the 2021 health RBC working agenda. The motion passed unanimously.

3. Referred Proposal 2021-02-CA to the Capital Adequacy (E) Task Force for Exposure

Mr. Drutz said that the Working Group exposed proposal 2021-02-CA for a 30-day comment period ending March 12, and no comments were received. He said that the purpose of the proposal is to provide clarifying language for the inclusion of incentives in the managed care credit instructions and blank.

Hearing no objections, the Working Group referred proposal 2021-02-CA to the Capital Adequacy (E) Task Force for exposure on all lines of business.

4. Heard an Update from the Academy on Investment Income in the Underwriting Risk Component and Exposed Proposal 2021-04-CA

Mr. Drutz said the Working Group requested the Academy’s assistance in developing adjusted factors to include investment income for Columns 1–4 on the Experience Fluctuation Risk page. The Academy provided the adjusted factors in its letter dated Feb. 22, 2021 (Attachment \_\_). Derek Skoog (Academy) said that the Academy used the same methodology used in its previous letter where the Academy had deconstructed the current factors assuming that they currently have no investment income attributed to them based on its understanding of how they were developed. Then using a combination of the Academy’s knowledge of industry completion factors by product as well as industry loss ratios, the Academy developed a range of potential output risk factors that would correspond to do those assumptions. Mr. Skoog said when it comes to determining the investment return rate, there are a number of factors worthy of consideration, and the Academy has included a range of potential results within its letter.

Mr. Drutz said that a summary (Attachment \_\_) of the number of companies whose RBC ratio changed by both the percentage change and point change for the 0.5%, 1%, 1.5% and 2% investment returns was included in the impact analysis. He said that

a majority of companies had a 0% to 1.5% percent change with the 0.5% investment return, while a majority of companies had about a 0% to 2.5% change in the 1% investment return, a 0% to 3% change with the 1.5% investment return, and 0% to 3.5% change with the 2% investment return.

Mr. Drutz said that the Working Group will need to determine the frequency in which the factors will need to be reviewed and if a benchmark should be established in updating the factors, such as Treasury bonds. He said the five-year Treasury Bond yield for 2021 has ranged from 0.36 to 0.84%, and five years would seem to be the longest time frame to consider based on his understanding of the health portfolios with an average maturity around five years. Mr. Drutz said that proposal 2021-04-CA includes the 0.5% and 1% investment return adjustment to the underwriting risk factors as Option 1 and Option 2.

Hearing no objections, the Working Group agreed to expose proposal 2021-04-CA for a 30-day public comment period ending April 16. The exposure will include both the 0.5% and 1% investment return factors and the Academy's Feb. 22 letter. Following the initial exposure, the proposal will then be referred to the Capital Adequacy (E) Task Force for a subsequent exposure for all lines of business.

#### 5. Received an Update on the Bond Factor Impact Analysis

Mr. Drutz said NAIC staff are working on the impact analysis for the 20 designation bond factors based on year-end 2020 reporting. He said the Working Group expects to meet in early April to discuss the results for both the two- and five-year time horizon factors. He said the Working Group will need to determine which factors to move forward with and expose by no later than April 30.

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

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Health Bond Based Risk Factors																				
NAIC Designation Category	1A	1B	1C	1D	1E	1F	1G	2A	2B	2C	3A	3B	3C	4A	4B	4C	5A	5B	5C	6
Current (2020)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	1.0%	1.0%	1.0%	2.0%	2.0%	2.0%	4.5%	4.5%	4.5%	10.0%	10.0%	10.0%	30.0%
AAA Proposed 2-Yr Time Horizon	0.1%	0.1%	0.1%	0.2%	0.3%	0.5%	0.7%	1.0%	1.2%	1.5%	6.9%	7.6%	8.3%	8.9%	9.7%	11.0%	12.3%	13.7%	15.1%	30.0%
AAA Proposed 5-Yr Time Horizon	0.3%	0.5%	0.8%	1.1%	1.4%	1.6%	1.9%	2.2%	2.5%	3.1%	6.9%	7.6%	8.3%	8.9%	9.7%	11.0%	12.3%	13.7%	15.1%	30.0%
Difference Between Current and 2-Yr. Time Horizon	0.2%	0.2%	0.2%	0.1%	0.0%	-0.2%	-0.4%	0.0%	-0.2%	-0.5%	-4.9%	-5.6%	-6.3%	-4.4%	-5.2%	-6.5%	-2.3%	-3.7%	-5.1%	0.0%
Difference Between Current and 5-Yr. Time Horizon	0.0%	-0.2%	-0.5%	-0.8%	-1.1%	-1.3%	-1.6%	-1.2%	-1.5%	-2.1%	-4.9%	-5.6%	-6.3%	-4.4%	-5.2%	-6.5%	-2.3%	-3.7%	-5.1%	0.0%

2020 RBC Charges by Company Size - Current verse 2-Yr Time Horizon Bond RBC Charges

(\$ Thousand)							
TAC Size	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Total Adjusted Capital	626,604	2,520,351	7,681,874	26,324,226	56,279,787	84,969,462	178,402,305
H0 - Current	1,616	6,164	61,725	341,798	1,478,217	2,844,144	4,733,664
H1 - Current (2020)	6,424	39,083	277,113	894,857	3,865,754	4,922,331	10,005,562
H1 - (2-Yr Horizon)	6,401	40,024	294,719	934,429	4,068,527	5,252,233	10,596,333
H1 % Change	0%	2%	6%	4%	5%	7%	6%
H2 - Current	119,070	638,828	2,144,178	7,996,731	16,346,411	14,029,327	41,274,546
H3 - Current	19,340	51,487	182,227	619,007	1,557,970	1,323,431	3,753,462
H4 - Current	32,903	121,492	350,202	840,033	2,268,100	3,427,769	7,040,498
ACL - Current	71,340	358,133	1,218,192	4,510,535	9,989,052	9,832,171	25,979,423
ACL - Proposed	71,405	358,187	1,234,410	4,512,619	10,017,979	9,887,772	26,082,372
ACL % Change	0.092%	0.015%	1.331%	0.046%	0.290%	0.566%	0.396%
# of Companies	259	204	165	181	115	29	953

2020 RBC Charges by Company Size - Current verse 5-Yr Time Horizon Bond RBC Charges

(\$ Thousand)							
TAC Size	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Total Adjusted Capital	626,604	2,520,351	7,681,874	26,324,226	56,279,787	84,969,462	178,402,305
H0 - Current	1,616	6,164	61,725	341,798	1,478,217	2,844,144	4,733,664
H1 - Current (2020)	6,424	39,083	277,113	894,857	3,865,754	4,922,331	10,005,562
H1 - (5-Yr Horizon)	6,890	48,308	355,345	1,128,381	4,434,245	5,730,853	11,704,022
H1 % Change	7%	24%	28%	26%	15%	16%	17%
H2 - Current	119,070	638,828	2,144,178	7,996,731	16,346,411	14,029,327	41,274,546
H3 - Current	19,340	51,487	182,227	619,007	1,557,970	1,323,431	3,753,462
H4 - Current	32,903	121,492	350,202	840,033	2,268,100	3,427,769	7,040,498
ACL - Current	71,340	358,133	1,218,192	4,510,535	9,989,052	9,832,171	25,979,423
ACL - Proposed	71,485	358,708	1,246,760	4,528,274	10,062,402	9,973,666	26,241,296
ACL % Change	0.204%	0.161%	2.345%	0.393%	0.734%	1.439%	1.008%
# of Companies	259	204	165	181	115	29	953

2020 Health RBC - Comparison of Action Levels by Company Size Between Current and 2-Yr Time Horizon Bonds RBC Charges

		2020 RBC Action Level under Current RBC Formula					Total
		ACL	RAL	CAL	Trend Test	No Action	Total
RBC Action Level with 2-Yr Time Horizon Bond RBC Charges	ACL	1					1
	RAL		3				3
	CAL			4			4
	Trend Test				7		7
	No Action					938	938
Total		1	3	4	7	938	953

2020 Health RBC - Comparison of Action Levels by Company Size Between Current and 5-Yr Time Horizon Bonds RBC Charges

		2020 RBC Action Level under Current RBC Formula					Total
		ACL	RAL	CAL	Trend Test	No Action	Total
RBC Action Level with 5-Yr Time Horizon Bond RBC Charges	ACL	1					1
	RAL		3				3
	CAL			4			4
	Trend Test				7	1	8
	No Action					937	937
Total		1	3	4	7	938	953

Distributions of % Change in H1 Charges by Company Size under 2-Yr Time Horizon Bond RBC Charges

H1 % Change\TAC	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Less than -50%	4	6		2		1	13
-50% to -25%	4	5	5	4		1	19
-25% to -15%	3	5	6	5			19
-15% to -5%	6	12	9	14	3	1	45
-5% to 5%	230	141	94	97	64	15	641
5% to 15%	7	16	17	22	26	5	93
15% to 25%	3	8	14	18	7	2	52
25% to 50%	2	8	11	8	6	2	37
Greater than 50%		3	9	11	9	2	34
Subtotal	259	204	165	181	115	29	953

Distributions of % Change in H1 Charges by Company Size under 5-Yr Time Horizon Bond RBC Charges

H1 % Change\TAC	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Less than -50%	1			2			3
-50% to -25%							0
-25% to -15%							0
-15% to -5%	1						1
-5% to 5%	228	126	58	41	24	6	483
5% to 15%	6	12	13	18	27	9	85
15% to 25%	3	3	6	9	9	3	33
25% to 50%	4	8	19	14	8	4	57
Greater than 50%	16	55	69	97	47	7	291
Subtotal	259	204	165	181	115	29	953

Distributions of % Changes in ACL RBC by Company Size under 2-Yr Time Horizon Bond RBC Charges

ACL RBC % Change\TAC	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Less than -50%	1						1
-50% to -25%	1	1		1			3
-25% to -15%		1					1
-15% to -5%	5			1			6
-5% to 5%	250	200	161	178	115	29	933
5% to 15%	1	1	1				3
15% to 25%	1		1				2
25% to 50%		1	2	1			4
Greater than 50%							0
Subtotal	259	204	165	181	115	29	953

Distributions of % Changes in ACL RBC by Company Size under 5-Yr Time Horizon Bond RBC Charges

ACL RBC % Change\TAC	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Less than -50%	1						1
-50% to -25%							0
-25% to -15%							0
-15% to -5%	1						1
-5% to 5%	247	199	156	173	113	27	915
5% to 15%	5	2	3	3	2	2	17
15% to 25%	1	1	2	1			5
25% to 50%	1		1				2
Greater than 50%	3	2	3	4			12
Subtotal	259	204	165	181	115	29	953

Distributions of % Changes in RBC Ratios by Company Size under 2-Yr Time Horizon Bond RBC Charges

RBC Ratio % Change\TAC	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Less than -50%							0
-50% to -25%			1				1
-25% to -15%	1	1	1	1			4
-15% to -5%	1	1	2				4
-5% to 5%	250	200	161	178	115	29	933
5% to 15%	5						5
15% to 25%				1			1
25% to 50%		1		1			2
Greater than 50%	2	1					3
Subtotal	259	204	165	181	115	29	953

Distributions of % Changes in RBC Ratios by Company Size under 5-Yr Time Horizon Bond RBC Charges

RBC Ratio % Change\TAC	0 - \$5M	\$5M - \$25M	\$25M - \$75M	\$75M - \$250M	\$250M - \$1B	Over \$1B	Total
Less than -50%	2	1	3	2			8
-50% to -25%	2	1		2			5
-25% to -15%	1		1	1			3
-15% to -5%	5	3	5	2	2	1	18
-5% to 5%	247	199	156	174	113	28	917
5% to 15%	1						1
15% to 25%							0
25% to 50%							0
Greater than 50%	1						1
Subtotal	259	204	165	181	115	29	953

**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       SMI RBC (E) Subgroup  
 C3 Phase II/ AG43 (E/A) Subgroup       P/C RBC (E) Working Group       Stress Testing (E) Subgroup

<b>DATE:</b> <u>04/23/2021</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Crystal Brown</u>	Agenda Item # <u>2021-09-H</u>
<b>TELEPHONE:</b> <u>816-783-8146</u>	Year <u>2021</u>
<b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Health RBC (E) Working Group</u>	<input type="checkbox"/> ADOPTED _____
<b>NAME:</b> <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <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       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 the factors for the 20 NAIC Designation Category Bonds based on a five-year time horizon for page XR006, XR007 and XR012. Modify the instructions to incorporate references for the bonds.

**REASON OR JUSTIFICATION FOR CHANGE \*\***

The reason for the change is to incorporate the new bond factors for the 20 NAIC Designation Categories for a five-year time horizon in both the blank and instructions. The factor includes the bond portfolio adjustment.

**Additional Staff Comments:**

\*\* This section must be completed on all forms.

Revised 11-2013

## OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS XR006

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/adjusted carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

### *Specific Instructions for Application of the Formula*

Column (2) – Schedule DL, Part 1 Book/Adjusted Carrying Value comes from Annual Statement Schedule DL, Part 1, Column (6) Securities Lending Collateral Assets reported On-Balance Sheet (Assets Page, Line 10).

Off-balance sheet collateral included in General Interrogatories Part 1, Lines 24.05 and 24.06 of the annual statement should agree with Line (40), Column (1).

Lines (1) through (27) – Bonds – Bond factors described on page XR007 – Fixed Income Assets.

Line (28) through (34) – Preferred Stock – Preferred stock factors described on page XR010 – Equity Assets.

Line (35) – Common Stock – Common stock factors described on page XR010 – Equity Assets.

Line (36) – Real Estate and Property and Equipment Assets – Real Estate and Property and Equipment Assets factors described on page XR011 – Property & Equipment Assets.

Line (37) – Other Invested Assets – Other invested assets factor described on page XR008 – Fixed Income Assets.

Line (38) – Mortgage Loans on Real Estate – Mortgage Loans on Real Estate factors described on page XR008 – Fixed Income Assets.

Line (39) – Cash, Cash Equivalents and Short-Term Investments – Cash, Cash Equivalents and Short-Term Investments factors described on page XR008 – Fixed Income Assets.

## FIXED INCOME ASSETS XR007 AND XR008

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds include item that meet the definition of a bond, regardless if the bond is long-term (reported on Schedule D-1), short-term (reported on schedule DA) or a cash equivalent



(reported on Schedule E-2.) Miscellaneous fixed income assets include non-bond items reported on the cash equivalent and short-term schedules, derivatives, mortgage loans, collateral loans, and other items reported on Schedule BA: Other Long-Term Invested Assets.

### **Bonds (XR007)**

The bond factors for investment grade bonds (NAIC Designation Category (1.A-2.C) are based on cash flow modeling. Each bond of a portfolio was annually tested for default (based on a “roll of the dice”) where the default probability varies by NAIC Designation Category and that year’s economic environment. The default probabilities were based on historical data intended to reflect a complete business cycle of favorable and unfavorable credit environments.

The risk of default was measured over a ~~five~~-year time horizon, based on the duration of ~~assets or liabilities~~ held for health companies.

The factors for NAIC Designation Category 3.A to 6 recognize that these non-investment grade bonds are reported at the lower of amortized cost or fair value. These bond risk factors are based on the market value fluctuation for each of the NAIC designation category compared to the market value fluctuation of stocks during the 2008-2009 financial crisis.

While the life and property/casualty formulas have a separate calculation for the bond size factor (based on the number of issuers in the RBC filer's portfolio), the health formula does not include a separate calculation, instead a bond size component was incorporated into the bond factors. A representative portfolio of 382 issuers was used in calculating the bond risk factors.

There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States, Other U.S. Government Obligations, and securities on the NAIC U.S. Government Money Market Fund List because it is assumed that there is no default risk associated with U.S. Government issued securities.

The book/adjusted carrying value of all bonds should be reported in Columns (1), (2) or (3). The bonds are split into twenty-one different risk classifications. These risk classifications are based on the NAIC Designation Category as defined and permitted in the Purposes and Procedures Manual of the NAIC Investment Analysis Office. The subtotal of Columns (1), (2) and (3) will be calculated in Colum (4). The RBC requirement will be automatically calculated in Column (5).

### **Miscellaneous Fixed Income Assets (XR008)**

The factor for cash is 0.3 percent. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This factor was based on the original unaffiliated NAIC 01 bond risk factor prior to the increased granularity of the NAIC Designation Categories in 2021, and reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company’s cash position is negative.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3 percent factor is equal to the factor for cash. The amount reported in Line (35) reflects the total from Schedule DA: Short-Term Investments (Line 33), less the short-term bonds (Line 34). (The short-term bonds reported in Line (34) should equal Schedule DA, Part 1, Column 7, Line 8399999.)

Mortgage loans (reported on Schedule B) and Derivatives (reported on Schedule DB) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.

The following investment types are captured on Schedule BA: Other Long-Term Invested Assets. Specific factors have been established for certain Schedule BA assets based on the nature of the investment. Those Schedule BA assets not specifically identified below receive a 20 percent factor (Line (43)).

- Collateral Loans reported on Line (40) receive a factor of 5 percent, consistent with other risk-based capital formulas studied by the Working Group.

- Working Capital Finance Investments: The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines (41) and (42), should equal the Notes to Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.
- Low income housing tax credit investments are reported in Column (1) in accordance with *SSAP No. 93—Low Income Housing Tax Credit Property Investments*.
  - Federal Guaranteed Low-Income Housing Tax Credit (LIHTC) investments are to be included in Line (44). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.
  - Federal Non-Guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line (45):
    - a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
    - b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.
  - State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (46).
  - State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line (47).
  - All Other LIHTC investments, state and federal LIHTC investments that do not meet the requirements of Lines (44) through (47) would be reported on Line (48).

## 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. 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.

#### Unaffiliated Common Stock

Federal Home Loan Bank Stock has characteristics more like a fixed income instrument rather than common stock. A 2.3 percent factor was chosen. The factor for other unaffiliated common stock is based on studies which indicate that a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time of loss in market value.

## ASSET CONCENTRATION XR012

The purpose of the asset concentration calculation is to reflect the additional risk of high concentrations of certain types of assets in single exposures, termed “issuers.” An issuer is a single entity, such as IBM or the Ford Motor Company. When the reporting entity has a large portion of its asset portfolio concentrated in only a few issuers, there is a heightened risk of insolvency if one of those issuers should default. An issuer may be represented in the reporting entity’s investment portfolio by a single security designation, such as a large block of NAIC Designation Category 2.A bonds, or a combination of various securities, such as common stocks, preferred stocks, and bonds. The additional RBC for asset concentration is applied to the ten largest issuers.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the ten largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds, unaffiliated preferred stock; affiliated common stock; affiliated preferred stock; property and equipment; U.S. government full faith and credit, other U.S. government obligations, and NAIC U.S. government money market fund list securities; NAIC 01 bonds and unaffiliated preferred stock; any other asset categories with risk-based capital factors less than 1 percent, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the federal Investment Company Act of 1940 [Section 5(b) (1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting entity is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the federal Investment Company Act and providing this information upon request of the Commissioner, Director or Superintendent of the Department of Insurance. The reporting entity is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio, in order to determine whether a concentration charge is necessary. This information should be provided to the Commissioner, Director or Superintendent upon request.

The assets that **ARE INCLUDED** in the calculation when determining the 10 largest issuers are as follows:

- NAIC Designation Category 2.A – 2.C Bonds
- NAIC Designation Category 3.A – 3.C Bonds
- NAIC Designation Category 4.A – 4.C Bonds
- NAIC Designation Category 5.A – 5.C Bonds
- Collateral Loans
- Mortgage Loans
- NAIC 02 Unaffiliated Preferred Stock
- NAIC 03 Unaffiliated Preferred Stock
- NAIC 04 Unaffiliated Preferred Stock
- NAIC 05 Unaffiliated Preferred Stock
- Other Long-Term Assets
- NAIC 02 Working Capital Finance Investments
- Federal Guaranteed Low Income Housing Tax Credits
- Federal Non-Guaranteed Low Income Housing Tax Credits
- State Guaranteed Low Income Housing Tax Credits
- State Non-Guaranteed Low Income Housing Tax Credits

All Other Low Income Housing Tax Credits  
Unaffiliated Common Stock

The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) for assets held in the 10 largest issuers. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in Column (2), Lines (1) through (26). Aggregate all similar asset types before entering the amount in Column (2). To determine the 10 largest issuers, first pool all of the assets subject to the concentration factor. From this pool, aggregate the various securities by issuer. The aggregate book/adjusted carrying values for the assets are computed, and the 10 largest are subject to the concentration factor. For example, an organization might own \$6,000,000 in NAIC Designation Category 2.A bonds of IBM, plus \$4,000,000 in NAIC Designation Category 2.C plus \$5,000,000 of common stock. The total investment in that issuer is \$15,000,000. If that is the largest issuer, then the identifier ("IBM Corporation") would be entered in the space allowed for the first Issuer Name, and the \$6,000,000 would be entered under the book/adjusted carrying value column for Line (1) (NAIC Designation Category 2.A Bonds) \$4,000,000 would be entered on Line (3) (NAIC Designation Category 2.C Bonds) and the \$5,000,000 would be entered on Line (22) (Unaffiliated Common Stock).

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS

Asset Category	Annual Statement Source	(1) Off-Balance Sheet Collateral Book/Adjusted Carrying Value	(2) Schedule DL, Part 1 Book/Adjusted Carrying Value	(3) Subtotal	(4) Factor	RBC Requirement
<u>Fixed Income Assets</u>						
<u>Bonds</u>						
(1) NAIC 1.A - U.S. Government Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to A/S Instructions)	Company Records	0	0	0	0.000	0
(2) NAIC Designation Category 1.A Bonds	Company Records	0	0	0	0.003	0
(3) NAIC Designation Category 1.B Bonds	Company Records	0	0	0	0.005	0
(4) NAIC Designation Category 1.C Bonds	Company Records	0	0	0	0.008	0
(5) NAIC Designation Category 1.D Bonds	Company Records	0	0	0	0.011	0
(6) NAIC Designation Category 1.E Bonds	Company Records	0	0	0	0.014	0
(7) NAIC Designation Category 1.F Bonds	Company Records	0	0	0	0.016	0
(8) NAIC Designation Category 1.G Bonds	Company Records	0	0	0	0.019	0
(9) Total NAIC 01 Bonds	Sum of Lines (1) through (8)	0	0	0		0
(10) NAIC Designation Category 2.A Bonds	Company Records	0	0	0	0.022	0
(11) NAIC Designation Category 2.B Bonds	Company Records	0	0	0	0.025	0
(12) NAIC Designation Category 2.C Bonds	Company Records	0	0	0	0.031	0
(13) Total NAIC 02 Bonds	Sum of Lines (10) through (12)	0	0	0		0
(14) NAIC Designation Category 3.A Bonds	Company Records	0	0	0	0.069	0
(15) NAIC Designation Category 3.B Bonds	Company Records	0	0	0	0.076	0
(16) NAIC Designation Category 3.C Bonds	Company Records	0	0	0	0.083	0
(17) Total NAIC 03 Bonds	Sum of Lines (14) through (16)	0	0	0		0
(18) NAIC Designation Category 4.A Bonds	Company Records	0	0	0	0.089	0
(19) NAIC Designation Category 4.B Bonds	Company Records	0	0	0	0.097	0
(20) NAIC Designation Category 4.C Bonds	Company Records	0	0	0	0.110	0
(21) Total NAIC 04 Bonds	Sum of Lines (18) through (20)	0	0	0		0
(22) NAIC Designation Category 5.A Bonds	Company Records	0	0	0	0.123	0
(23) NAIC Designation Category 5.B Bonds	Company Records	0	0	0	0.137	0
(24) NAIC Designation Category 5.C Bonds	Company Records	0	0	0	0.151	0
(25) Total NAIC 05 Bonds	Sum of Lines (22) through (24)	0	0	0		0
(26) Total NAIC 06 Bonds	Company Records	0	0	0	0.300	0
(27) Total Bonds	Lines (9) + (13) + (17) + (21) + (25) + (26)	0	0	0		0
<u>Equity Assets</u>						
<u>Preferred Stock - Unaffiliated</u>						
(28) NAIC 01 Unaffiliated Preferred Stock	Company Records			0	0.003	0
(29) NAIC 02 Unaffiliated Preferred Stock	Company Records			0	0.010	0
(30) NAIC 03 Unaffiliated Preferred Stock	Company Records			0	0.020	0
(31) NAIC 04 Unaffiliated Preferred Stock	Company Records			0	0.045	0
(32) NAIC 05 Unaffiliated Preferred Stock	Company Records			0	0.100	0
(33) NAIC 06 Unaffiliated Preferred Stock	Company Records			0	0.300	0
(34) Total Unaffiliated Preferred Stock	Sum of Lines (28) through (33)	0	0	0		0
(35) Unaffiliated Common Stock	Company Records			0	0.150	0
(36) Real Estate and Property & Equipment Assets	Company Records			0	0.100	0
(37) Other Invested Assets	Company Records			0	0.200	0
(38) Mortgage Loans on Real Estate	Company Records			0	0.050	0
(39) Cash, Cash Equivalents and Short-Term Investments (Not reported on Bonds above)	Company Records			0	0.003	0
(40) Total	Lines (27) + (34) + (35) + (36) + (37) + (38) + (39)	0	0	0		0

Denotes items that must be manually entered on the filing software

**FIXED INCOME ASSETS  
BONDS**

	(1)	(2)	(3)	(4)	(5)
	Long-Term Bonds Schedule D, Part 1 Book/Adjusted Carrying Value L2 thru 26 = Sch D Pt1F	Short-Term Investments Schedule DA, Part 1 Book/Adjusted Carrying Value L2 thru 26 = Sch DA Pt1F	Cash Equivalents Schedule E, Part 2 Book/Adjusted Carrying Value L2 thr 26 = Sch E Pt2F	Subtotal C(1) + C(2) + C(3)	RBC Requirement
Annual Statement Source				Factor	
(1) NAIC 1.A - U.S. Government Full Faith and Credit, Other U.S. Government Obligations, and NAIC U.S. Government Money Market Fund List (Refer to A/S Instructions)	C(1)=Sch D, Pt 1, C11 L0599999 C(2)=Sch DA, Pt 1, C7 L0599999 C(3)=Sch E, Pt 2, C7 L0599999 + L8599999	0	0	0	0
(2) NAIC Designation Category 1.A	Footnote Amt 1 L000001A- L(1)	0	0	0	0.000
(3) NAIC Designation Category 1.B	Footnote Amt 2 L000001A	0	0	0	0.003
(4) NAIC Designation Category 1.C	Footnote Amt 3 L000001A	0	0	0	0.005
(5) NAIC Designation Category 1.D	Footnote Amt 4 L000001A	0	0	0	0.008
(6) NAIC Designation Category 1.E	Footnote Amt 5 L000001A	0	0	0	0.011
(7) NAIC Designation Category 1.F	Footnote Amt 6 L000001A	0	0	0	0.014
(8) NAIC Designation Category 1.G	Footnote Amt 7 L000001A	0	0	0	0.016
(9) Total NAIC 01 Bonds	Sum of Ls (1) through (8)	0	0	0	0.019
(10) NAIC Designation Category 2.A	Footnote Amt 1 L000001B	0	0	0	0.022
(11) NAIC Designation Category 2.B	Footnote Amt 2 L000001B	0	0	0	0.025
(12) NAIC Designation Category 2.C	Footnote Amt 3 L000001B	0	0	0	0.031
(13) Total NAIC 02 Bonds	Sum of Ls (10) through (12)	0	0	0	0.069
(14) NAIC Designation Category 3.A	Footnote Amt 1 L000001C	0	0	0	0.076
(15) NAIC Designation Category 3.B	Footnote Amt 2 L000001C	0	0	0	0.083
(16) NAIC Designation Category 3.C	Footnote Amt 3 L000001C	0	0	0	0.089
(17) Total NAIC 03 Bonds	Sum of Ls (14) through (16)	0	0	0	0.097
(18) NAIC Designation Category 4.A	Footnote Amt 1 L000001D	0	0	0	0.110
(19) NAIC Designation Category 4.B	Footnote Amt 2 L000001D	0	0	0	0.123
(20) NAIC Designation Category 4.C	Footnote Amt 3 L000001D	0	0	0	0.137
(21) Total NAIC 04 Bonds	Sum of Ls (18) through (20)	0	0	0	0.151
(22) NAIC Designation Category 5.A	Footnote Amt 1 L000001E	0	0	0	0
(23) NAIC Designation Category 5.B	Footnote Amt 2 L000001E	0	0	0	0
(24) NAIC Designation Category 5.C	Footnote Amt 3 L000001E	0	0	0	0
(25) Total NAIC 05 Bonds	Sum of Ls (22) through (24)	0	0	0	0
(26) Total NAIC 06 Bonds	Footnote Amt 1 L000001F	0	0	0	0.300
(27) Total Bonds RBC	L(9) + L(13) + L(17) + L(21) + L(25) + L(26)	0	0	0	0

 Denotes items that must be vendor linked.

**ASSET CONCENTRATION**

		(1)		
Issuer Name				
Issuer		(2)	Factor	(3)
		<u>Bk/Adj Carrying Value</u>		<u>Additional RBC</u>
01	(1) NAIC Designation Category 2.A Bonds		<b>0.0220</b>	\$0
01	(2) NAIC Designation Category 2.B Bonds		<b>0.0250</b>	\$0
01	(3) NAIC Designation Category 2.C Bonds		<b>0.0310</b>	\$0
01	(4) NAIC Designation Category 3.A Bonds		<b>0.0690</b>	\$0
01	(5) NAIC Designation Category 3.B Bonds		<b>0.0760</b>	\$0
01	(6) NAIC Designation Category 3.C Bonds		<b>0.0830</b>	\$0
01	(7) NAIC Designation Category 4.A Bonds		<b>0.0890</b>	\$0
01	(8) NAIC Designation Category 4.B Bonds		<b>0.0970</b>	\$0
01	(9) NAIC Designation Category 4.C Bonds		<b>0.1100</b>	\$0
01	(10) NAIC Designation Category 5.A Bonds		<b>0.1230</b>	\$0
01	(11) NAIC Designation Category 5.B Bonds		<b>0.1370</b>	\$0
01	(12) NAIC Designation Category 5.C Bonds		<b>0.1490</b>	\$0
01	(13) Collateral Loans		0.0500	\$0
01	(14) Mortgages		0.0500	\$0
01	(15) NAIC 02 Unaffiliated Preferred Stock		0.0100	\$0
01	(16) NAIC 03 Unaffiliated Preferred Stock		0.0200	\$0
01	(17) NAIC 04 Unaffiliated Preferred Stock		0.0450	\$0
01	(18) NAIC 05 Unaffiliated Preferred Stock		0.1000	\$0
01	(19) Other Long-Term Invested Assets		0.1000	\$0
01	(20) NAIC 02 Working Capital Finance Investments		0.0125	\$0
01	(21) Federal Guaranteed Low Income Housing Tax Credits		0.0014	\$0
01	(22) Federal Non-Guaranteed Low Income Housing Tax Credits		0.0260	\$0
01	(23) State Guaranteed Low Income Housing Tax Credits		0.0014	\$0
01	(24) State Non-Guaranteed Low Income Housing Tax Credits		0.0260	\$0
01	(25) All Other Low Income Housing Tax Credits		0.1500	\$0
01	(26) Unaffiliated Common Stock		0.1500	\$0
01	(27) Total of Issuer = Lines (1) through (26)	\$0		\$0

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  Denotes items that must be manually entered on filing software.

## Capital Adequacy (E) Task Force

### RBC Proposal Form

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force | <input 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"/> C3 Phase II/ AG43 (E/A) Subgroup           | <input type="checkbox"/> P/C RBC (E) Working Group        |  |

<b>DATE:</b> <u>3-17-21</u>	<b><u>FOR NAIC USE ONLY</u></b>
<b>CONTACT PERSON:</b> <u>Crystal Brown</u>	Agenda Item # <u>2021-04-CA</u>
<b>TELEPHONE:</b> <u>816-783-8146</u>	Year <u>2021</u>
<b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u>	<b><u>DISPOSITION</u></b>
<b>ON BEHALF OF:</b> <u>Health RBC (E) Working Group</u>	<input type="checkbox"/> ADOPTED _____
<b>NAME:</b> <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
<b>TITLE:</b> <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
<b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
<b>ADDRESS:</b> <u>PO Box 40255</u>	<input checked="" type="checkbox"/> EXPOSED <u>4-16-21</u>
<u>Olympia, WA 98504-0255</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

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

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

#### DESCRIPTION OF CHANGE(S)

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

#### REASON OR JUSTIFICATION FOR CHANGE \*\*

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

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

#### Additional Staff Comments:

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

3-17-21 cgb The Working Group exposed the proposal for 30-days with comments due back on April 16, 2021.

\*\* This section must be completed on all forms.

Revised 2-2019



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

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

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

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

**Claims Experience Fluctuation**

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

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

or

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

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

application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using the health organization's actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports, the RBC results for all of the formula components shall be calculated using actual data.

### **L(1) through L(21)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

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

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

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

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

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

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

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

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

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

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

Line (15) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

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

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

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

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

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than \$750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and \$750,000.
- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity’s participation in the stop-loss layer (up to \$750,000 less retention).

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

Examples of the calculation are presented below:

**EXAMPLE 1 (Reporting entity provides Comprehensive Care):**

Highest Attachment Point (Retention)	\$100,000
Reinsurance Coverage	90% of \$500,000 in excess of \$100,000
Maximum reinsured coverage	\$600,000 (\$100,000 + \$500,000)
Maximum Ret. Risk =	\$100,000 deductible
	+ \$150,000 (\$750,000 – \$600,000)
	+ <u>\$ 50,000</u> (10% of (\$600,000 – \$100,000) coverage layer)
	= \$300,000

**EXAMPLE 2 (Reporting entity provides Comprehensive Care):**

Highest Attachment Point (Retention)	\$75,000
Reinsurance Coverage	90% of \$1,000,000 in excess of \$75,000
Maximum reinsured coverage	\$1,075,000 (\$75,000 + \$1,000,000)

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

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

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

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

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

## PROPERTY & CASUALTY

### PR020 - Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental and Vision

(Underwriting Risk – Experience Fluctuation Factor in the LRBC Formula)

The underwriting risk generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this worksheet comes from PR021 Underwriting Risk - Managed Care Credit.

Description from *Life Risk-Based Capital Report Including Overview & Instructions*:

Underwriting risk is present when the next dollar of unexpected claims payments comes directly out of the company'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, an insurer may charge an individual \$100 in premium in exchange for a guaranty that all medical costs will be paid by the insurer. If the individual incurs \$101 in claims costs, the company'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 insurer is not at risk for excessive claims payments, such as when an insurer agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claims costs, so the risk of excessive claims experience is borne by the self-insured employer, not the insurer. The underwriting risk section of the RBC formula, therefore, requires some adjustments to remove non-risk business (both premiums and claims) before the RBC requirement is calculated.

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10.1) through (10.4) of PR021 will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

### 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 factors.

or

B. An alternate risk charge that addresses the risk of catastrophic claims on any single individual. The alternate risk charge is calculated for each type of health coverage, but only the largest value is compared to the value from A. above for that type. The alternate risk charge is equal to a 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 two times the maximum or \$1,500,000 for Comprehensive Medical; two times the maximum or \$50,000 for each of Medicare Supplement business and dental coverage and six times the maximum or \$1,500,000 for Stand-Alone Medicare Part D coverage.

Line (1) through Line (18)

**There are four lines of business used in the property/casualty RBC formula for calculating the RBC requirement in this worksheet. Other health coverages will continue to use the factors on PR019 Health Premiums. The four lines of business are Column (1) Comprehensive Medical and Hospital; Column (2) Medicare Supplement Column (3) Dental & Vision and Column (4) Stand-Alone Medicare Part D coverage. Each of the four lines of business has its own column in the Underwriting Risk – Premium Risk table. The categories listed in the columns of this worksheet include premiums plus all risk revenue that is received from another health entity in exchange for medical services provided to such Health entity’s members. The descriptions of the items are as follows:**

Comprehensive Medical & Hospital

Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This includes Medicare Advantage, with or without prescription drug benefits. This category DOES NOT include administrative services contracts (ASC) or administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in PR022 Underwriting Risk – Other, Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Program (FEHBP) business, which is reported on Line (3) of PR022 Underwriting Risk – Other. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000.

Medical Only (non-hospital professional services)

Include in Comprehensive Medical.

Medicare Supplement

This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Medicare risk business is reported under comprehensive medical and hospital.

Dental & Vision

These are premiums for policies providing for dental or vision only coverage issued as stand-alone dental or vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Stand-Alone Medicare Part D Coverage

Includes policies and contracts providing the standard coverage for individuals enrolled in Stand-Alone Medicare Part D and the insurance is a federally approved PDP with risk corridor protection. It does not include risk revenue for Supplemental benefits within Stand-Alone Medicare Part D coverage that is a portion of the PDP’s approved package. It does not include employer coverage unless the coverage meets the above criteria. Where there is a federal subsidy to the employer in lieu of risk corridor protection, the premiums are to be reported as “Other Health.”

Other Health Coverages

Include in the appropriate line on PR019 Health Premiums.

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

Line (1) Premium



This is the amount of money charged by the insurer for the specified benefit plan. It is the earned premium, net of reinsurance. It does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-risk business; or premium for the Federal Employees Health Benefit Programs (FEHBP), which has a risk factor relating to incurred claims reported separately under PR022 Underwriting Risk – Other, Line (3).

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.

For Stand-Alone Medicare Part D Coverage, this will include only certain amounts paid by the individual, an employer or CMS. See Appendix 2 for details of what is and is not premium income.

Line (2) Title XVIII Medicare

**This is the earned amount of money charged by the insurer (net of reinsurance) for Medicare risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans.**

Line (3) Title XIX Medicaid

This is the earned amount of money charged by the insurer for Medicaid risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicaid subscribers. Revenue from Stand-Alone Medicare Part D coverage under the low-income subsidy (cost sharing portion) and low-income subsidy (premium portion) are not included in this line.

Line (4) Other Health Risk Revenue

Earned amounts charged by the reporting company 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 insurance company (Health). 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 insurance company to the company 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 company from a health entity. This revenue is reported in the business risk section of the formula as health ASO/ASC and limited risk revenue.

Line (5) Underwriting Risk Revenue

**The sum of Lines (1.3) through (4).**

Line (6) 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 insurer. Paid claims include capitation and all other payments to providers for services to covered lives, as well as reimbursement directly to insureds (or their providers) for covered services. Paid claims also include salaries paid to company employees that provide medical services to covered lives and related expenses. This line does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.**

**Column (1) claims come from Annual Statement, Schedule H, Part 5 Column 1 Line D13 less the amounts reported as incurred claims for Administrative Services Contracts (ASC) in Line (8) of PR013 and Federal Employee Health Benefit Plan (FEHBP) in Line (3) of PR022. (Note that Medicare supplement claims could be double-counted if included in Column 1 of Schedule H, Part 5 rather than Column (3)). Column (2) claims come from General Interrogatories Part 2, Line 1.5. Column (3) dental claims come from Schedule H, Part 5, Column 2, Line D13.)**

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix 2). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim 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.

Line (7) 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 or charges to nonmember/insured of the company where the provider of the service receives no additional compensation from the company) and when such revenue was excluded from the pricing of medical benefits.**

Line (8) Underwriting Risk Incurred Claims

**Line (6) minus Line (7).**

Line (9) Underwriting Risk Claims Ratio

**Line (8) / Line (5). If either Line (5) or Line (8) is zero or negative, Line (9) is zero.**

Line (10) Underwriting Risk Factor

A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.

	\$0 - \$3 Million	\$3-\$25 Million	Over \$25 Million
Comprehensive Medical	0.150	0.150	0.090
Medicare Supplement	0.105	0.067	0.067
Dental & Vision	0.120	0.076	0.076
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

**Commented [BC1]:** These factors will be updated for the CapAd exposure when the investment return has been determined.

Line (11) Base Underwriting Risk RBC

**Line (5) x Line (9) x Line (10.3).**

Line (12) Managed Care Discount

**For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental, 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 claims payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (12) of PR021 Underwriting Risk - Managed Care Credit. 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 (12) of PR021 Underwriting Risk - Managed Care Credit.

Line (13) Base RBC After Managed Care Discount  
 Line (11) x Line (12).

Line (14) RBC Adjustment for Individual  
**The average Experience Fluctuation Risk charge is increased by 20 percent for the portion relating to Individual Medical Expense premiums in Column (1). Other types of health coverage do not differentiate between Individual and Group. The additional time necessary to develop sufficient data to make a premium filing with states and then to implement the premium increase was modeled to calculate this factor.**

Line (15) Maximum Per-Individual Risk After Reinsurance  
 This is the maximum loss after reinsurance 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 non-proportional reinsurance or stop-loss protection with the highest attachment point is capped at less than \$750,000 per insured for Comprehensive Medical and \$25,000 for the other three lines, the maximum retained loss will be equal to such attachment point plus the difference between the coverage maximum per claim and \$750,000 or \$25,000, whichever is applicable.
- \* Where the non-proportional reinsurance or stop-loss protection is subject to participation by the company, the maximum retained risk as calculated above will be increased by the company's participation in claims in excess of the attachment point, but not to exceed \$750,000 for Comprehensive Medical and \$25,000 for the other three coverages.

If there is no specific stop-loss or reinsurance in place, enter the largest amount payable (within a calendar year) or \$9,999,999 if there is no limit.

**Examples of the calculation are presented below:**

EXAMPLE 1 (Insurer 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 Retained Risk =	\$100,000 deductible
	+\$150,000 (\$750,000 - \$600,000)
	<u>+\$50,000</u> (10% of \$500,000 coverage layer)
	= \$300,000

EXAMPLE 2 (Insurer 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 Retained Risk =	<table border="0" style="margin-left: 20px;"> <tr> <td>\$75,000 deductible</td> </tr> <tr> <td>+ \$0 (\$750,000 - \$1,075,000)</td> </tr> <tr> <td><u>+\$67,500</u> (10% of \$675,000 coverage layer)</td> </tr> <tr> <td>= \$142,500</td> </tr> </table>	\$75,000 deductible	+ \$0 (\$750,000 - \$1,075,000)	<u>+\$67,500</u> (10% of \$675,000 coverage layer)	= \$142,500
\$75,000 deductible					
+ \$0 (\$750,000 - \$1,075,000)					
<u>+\$67,500</u> (10% of \$675,000 coverage layer)					
= \$142,500					

Line (16) Alternate Risk Charge  
**Twice the amount in Line (15), subject to a maximum of \$1,500,000 for comprehensive medical and \$50,000 for Medicare Supplement and Dental. Six times the amount in Line (15), subject to maximum of \$150,000 for Stand-Alone Medicare Part D Coverage.**

Line (17) Net Alternate Risk Charge  
 The largest value from Line (16) is retained for that column in line (17) and all others are ignored.

Line (18) Net Underwriting Risk RBC  
**The maximum of Line (14) and Line (17).**

**LIFE**

## Underwriting Risk – Experience Fluctuation Risk

LR020

The underwriting risk generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this worksheet comes from LR022 Underwriting Risk – Managed Care Credit.

Underwriting risk is present when the next dollar of unexpected claims payments comes directly out of the company'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, an insurer may charge an individual \$100 in premium in exchange for a guaranty that all medical costs will be paid by the insurer. If the individual incurs \$101 in claims costs, the company'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 insurer is not at risk for excessive claims payments, such as when an insurer agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claims costs, so the risk of excessive claims experience is borne by the self-insured employer, not the insurer. The underwriting risk section of the RBC formula, therefore, requires some adjustments to remove non-risk business (premiums and claims) before the RBC requirement is calculated.

For Stand-Alone Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) of LR022 will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

### 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 factors.

or

- B. An alternate risk charge that addresses the risk of catastrophic claims on any single individual. The alternate risk charge is calculated for each type of health coverage, but only the largest value is compared to the value from A. above for that type. The alternate risk charge is equal to a 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 two times the maximum or \$1,500,000 for Comprehensive Medical; two times the maximum or \$50,000 for each of Medicare Supplement business and dental coverage and six times the maximum or \$150,000 for Stand-Alone Medicare Part D coverage.

### Line (1) through Line (18)

There are four lines of business used in the life and fraternal RBC formula for calculating the RBC requirement in this worksheet. Other health coverages will continue to use the factors on LR019 Health Premiums. The four lines of business are: Column (1) Comprehensive Medical and Hospital; Column (2) Medicare Supplement; Column (3) Dental & Vision; and Column (4) Stand-Alone Medicare Part D coverage. Each of the four lines of business has its own column in the

Underwriting Risk - Experience Fluctuation Risk table. The categories listed in the columns of this worksheet include premiums plus all risk revenue that is received from another reporting entity in exchange for medical services provided to its members.

The descriptions of the items are as follows:

Comprehensive Medical & Hospital

Includes policies providing for medical coverages, including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare supplement) and Medicaid risk coverage. This includes Medicare Advantage, with or without prescription drug benefits. This category DOES NOT include administrative services contracts (ASC) or administrative services only (ASO) contracts. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefits Program (FEHBP) business, which is reported on LR021 Underwriting Risk – Other, Line (3). The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000.

Medical Only (non-hospital professional services)

Include in Comprehensive Medical.

Medicare Supplement

This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Medicare risk business is reported under comprehensive medical and hospital.

Dental & Vision

These are premiums for policies providing for dental or vision-only coverage issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Stand-Alone Medicare Part D Coverage

Includes policies and contracts providing the standard coverage for individuals enrolled in Stand-Alone Medicare Part D and the insurance is a federally approved PDP with risk corridor protection. It does not include risk revenue for Supplemental benefits within Stand-Alone Medicare Part D coverage that is a portion of the PDP's approved package. It does not include employer coverage unless the coverage meets the above criteria. Where there is a federal subsidy to the employer in lieu of risk corridor protection, the premiums are to be reported as "Other Health."

Other Health Coverages

Include in the appropriate line on LR019 Health Premiums.

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

Line (1) Premium

This is the amount of money charged by the insurer for the specified benefit plan. It is the earned premium, net of reinsurance. It does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-risk business; or premium for the Federal Employees Health Benefit Programs (FEHBP), which has a risk factor relating to incurred claims reported separately under LR021 Underwriting Risk – Other, Line (3).

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.

For Stand-Alone Medicare Part D Coverage, this will include only certain amounts paid by the individual, an employer or CMS. See Appendix 3 for details of what is and is not premium income.

Line (2) Title XVIII Medicare

This is the earned amount of money charged by the insurer (net of reinsurance) for Medicare risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans.

Line (3) Title XIX Medicaid

This is the earned amount of money charged by the insurer for Medicaid risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicaid subscribers. Revenue from Stand-Alone Medicare Part D coverage under the low-income subsidy (cost sharing portion) and low-income subsidy (premium portion) are not included in this line.

Line (4) Other Health Risk Revenue

Earned amounts charged by the reporting company 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 managed care organization (MCO). 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 MCO to the company 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 company from another reporting entity. This revenue is reported in the business risk section of the formula as health ASO/ASC and limited risk revenue.

Line (5) Underwriting Risk Revenue

The sum of Lines (1.3) through (4).

Line (6) 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 insurer. Paid claims includes capitation and all other payments to providers for services to covered lives, as well as reimbursement directly to insureds (or their providers) for covered services. Paid claims also include salaries paid to company employees that provide medical services to covered lives and related expenses. Line (6) does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

Column (1) claims come from Schedule H, Part 5, Column 1 Line 13 less the amounts reported as incurred claims for administrative services contracts (ASC) in Line (51) of LR029 Business Risk and Federal Employee Health Benefit Program (FEHBP) in Line (3) of LR021 Underwriting Risk – Other. Note that Medicare supplement claims could be double-counted if included in Column 1 of Schedule H, Part 5 rather than Column 3. Column (2) for Medicare supplement should be net of reinsurance, the same as the other columns. Column (2) for Medicare supplement should use the direct claims from General Interrogatories Part 2, Line 1.5 after adjusting them for reinsurance. Column (3) dental claims come from Schedule H, Part 5, Column 2, Line 13.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix 3). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim 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.

Line (7) 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 or charges to non-member/insured of the company where the provider of the service receives no additional compensation from the company) and when such revenue was excluded from the pricing of medical benefits.

Line (8) Underwriting Risk Incurred Claims

Line (6) minus Line (7).

Line (9) Underwriting Risk Claims Ratio

Line (8) / Line (5). If either Line (5) or Line (8) is zero or negative, Line (9) is zero.

Line (10) Underwriting Risk Factor

A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical	0.150	0.150	0.090
Medicare Supplement	0.105	0.067	0.067
Dental	0.120	0.076	0.076
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

**Commented [BC2]:** These factors will be updated for the CapAd exposure when the investment return has been determined.

Line (11) Base Underwriting Risk RBC

Line (5) x Line (9) x Line (10.3).

Line (12) Managed Care Discount

For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental, 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 claims payments attributable to the managed care arrangements. The discount factor is from Column (3) Line (17) of LR022 Underwriting Risk – Managed Care Credit. 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 LR022 Underwriting Risk – Managed Care Credit.

Line (13) Base RBC After Managed Care Discount

Line (11) x Line (12).



Line (14) RBC Adjustment for Individual

The average experience fluctuation risk charge is increased by 20 percent for the portion relating to individual medical expense premiums in Column (1). Other types of health coverage do not differentiate individual and group. The additional time necessary to develop sufficient data to make a premium filing with states and then to implement the premium increase was modeled to calculate this factor.

Line (15) Maximum Per-Individual Risk After Reinsurance

This is the maximum loss after reinsurance 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 non-proportional reinsurance or stop-loss protection with the highest attachment point is capped at less than \$750,000 per insured for comprehensive medical and \$25,000 for the other three lines, the maximum retained loss will be equal to such attachment point plus the difference between the coverage maximum per claim and \$750,000 or \$25,000, whichever is applicable.
- \* Where the non-proportional reinsurance or stop-loss protection is subject to participation by the company, the maximum retained risk as calculated above will be increased by the company’s participation in claims in excess of the attachment point, but not to exceed \$750,000 for comprehensive medical and \$25,000 for the other three coverages.

If there is no specific stop-loss or reinsurance in place, enter the largest amount payable (within a calendar year), or \$9,999,999 if there is no limit.

Examples of the calculation are presented below:

EXAMPLE 1 (Insurer 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 Retained Risk =	\$100,000 deductible
	+ \$150,000 (\$750,000 - \$600,000)
	+ \$50,000 (10% of \$500,000 coverage layer)
	= \$300,000

EXAMPLE 2 (Insurer 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 Retained Risk =	\$75,000 deductible
	+ 0 (\$750,000 - \$1,075,000)

$\frac{+\$67,500}{=\$142,500}$  (10% of \$675,000 coverage layer)

Line (16) Alternate Risk Charge

Twice the amount in Line (15), subject to a maximum of \$1,500,000 for comprehensive medical and \$50,000 for Medicare Supplement and Dental. Six times the amount in Line (15), subject to a maximum of \$150,000 for Stand-Alone Medicare Part D Coverage.

Line (17) Net Alternate Risk Charge

The largest value from Line (16) is retained for that column in Line (17) and all others are ignored.

Line (18) Net Underwriting Risk RBC

The maximum of Line (14) and Line (17).

**UNDERWRITING RISK**

**Option 1 - 0.5% Investment Return**

**Experience Fluctuation Risk**

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

TIERED RBC FACTORS*						
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
\$0 - \$3 Million	0.1490	0.1040	0.1190	0.251	0.130	0.130
\$3 - \$25 Million	0.1490	0.0663	0.0755	0.251	0.130	0.130
Over \$25 Million	0.0893	0.0663	0.0755	0.151	0.130	0.130

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

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013.

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

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

**UNDERWRITING RISK**

**Option 2 - 1.0% Investment Return**

**Experience Fluctuation Risk**

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

TIERED RBC FACTORS*						
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
\$0 - \$3 Million	0.1480	0.1040	0.1190	0.251	0.130	0.130
\$3 - \$25 Million	0.1480	0.0656	0.0750	0.251	0.130	0.130
Over \$25 Million	0.0887	0.0656	0.0750	0.151	0.130	0.130

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

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013.

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

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

## **Property & Casualty RBC Formula and Life RBC Formula**

The factors used in the Underwriting Risk - Experience Fluctuation Risk page of the Property & Casualty RBC Formula and the Life RBC Formula are not displayed in the Blank. The factors are shown in the instructions. The factor change would be reflected in the formula of the Forecasting Spreadsheet for these two formulas.




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December 15, 2020

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

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

Dear Mr. Drutz:

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

### **Incorporation of Investment Income into H2 Risk Factors**

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

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

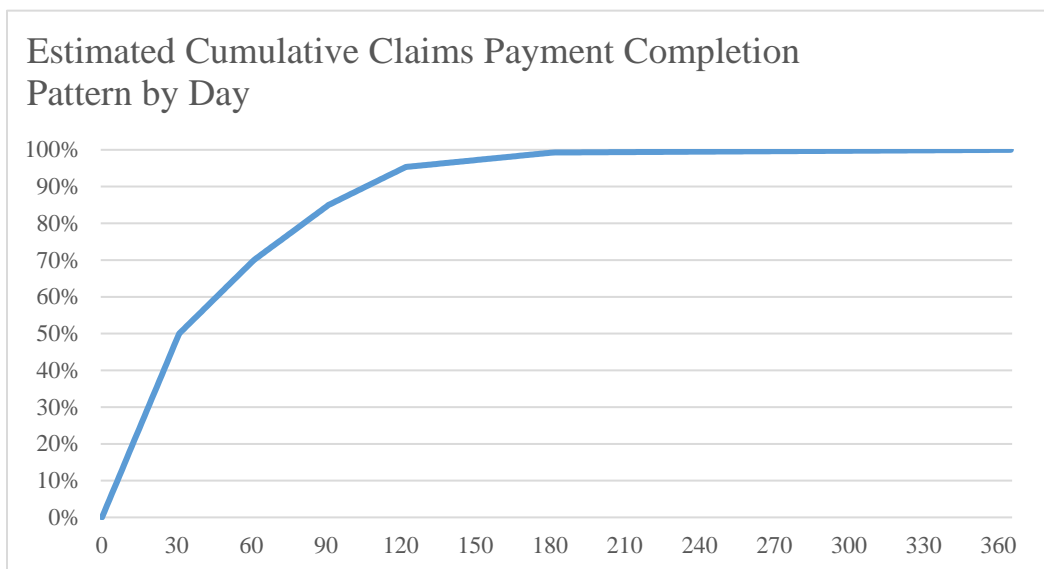
$$\text{Premium} * (\text{IIA} * \text{Risk\_Factor} + \text{Expense\_Ratio} - 1)$$

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

The  $IIA * Risk\_Factor$  expression is the discounted loss ratio at the target safety margin (87.5th percentile for P&C). Then, the  $IIA * Risk\_Factor + Expense\_Ratio - 1$  is the discounted operating loss at the target safety margin.

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



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

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

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

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

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

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

\*\*\*\*\*

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

Sincerely,

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

Cc: Crystal Brown: Senior Insurance Reporting Analyst






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*Objective. Independent. Effective.™*

January 11, 2021

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

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

Dear Mr. Drutz:

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

### **Incorporation of Investment Income into H2 Risk Factors**

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

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

The  $\text{IIA} * \text{Risk\_Factor}$  expression is the discounted loss ratio at the target safety margin (87.5th percentile for P&C). Then, the  $\text{IIA} * \text{Risk\_Factor} + \text{Expense\_Ratio} - 1$  is the discounted operating loss at the target safety margin.

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

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

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

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

\*\*\*\*\*

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

Sincerely,

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

Cc: Crystal Brown, Senior Insurance Reporting Analyst

# UNITEDHEALTH GROUP

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

April 16, 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 2021-04-CA.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group in regard to Proposal 2021-04-CA, as exposed for comment on 3/17/21, and the 2/22/21 letter from the American Academy of Actuaries (the “Academy letter”) that was exposed with the proposal. We appreciate your Working Group’s efforts to appropriately reflect investment income in the Health Risk-Based Capital (RBC) formula, and have previously expressed our support for this initiative in our comment letters of 8/31/20 and 1/6/21.

We fully support the changes that are recommended in Proposal 2021-04-CA. We concur that adjustments would be appropriate to the factors for Comprehensive Medical, Medicare Supplement, and Dental & Vision, and that consideration of other products can be deferred. We note that there is still an open issue as to the rate of investment return that should be used, and we offer some comments on that matter below. We also provide a comment on the Academy letter.

### Rate of investment return.

The adjustment to the underwriting risk factors depends on an assumption regarding the rate of investment return on health entities’ investment portfolios. Proposal 2021-04-CA offers two options: a rate of 0.5% and a rate of 1.0%. We believe that, whatever rate is ultimately selected, the Working Group should clearly state the rationale for the selection. This would have two important benefits: first, the rationale would help to support the appropriateness of the recommended adjustment; and second, the rationale would guide future updates of the adjustment. Accordingly, we set forth below our thoughts as to how the rate should be selected; we then present illustrative rates based on those concepts.

We believe that the selected rate of investment return should be based on historical averages, rather than some projection of future rates, as historical data provide an objective basis for determining the rate. We recognize four key components of determining the rate of investment return:

1. The average maturity of the investments.
2. The average quality of the investments.
3. The historical time period over which rates should be averaged. (This also has implications for the frequency of future updates.)
4. The degree of rounding to employ. (This also has implications for the threshold for change that would trigger a future update.)

We address each of these components under the corresponding heading below.

#### Average maturity.

As we stated in our comment letters of 1/6/21 and 1/13/21, we feel strongly that the maturity underlying the assumed rate of investment return should be consistent with the maturity underlying the bond factors. The same investments are being considered for both purposes, so there is no clear rationale for making a distinction. We believe that the degree of investment return that is reflected in the underwriting risk factors should be consistent with the degree of risk that is reflected in the bond factors. (We have explained in our comment letter of 1/13/21 why the approximately 1.6-month discounting period used by the Academy is not relevant to the average maturity assumption for the rate of investment return.)

We understand that the Working Group is currently considering maturities of 2 years and 5 years for the bond factors. We urge that whichever maturity is chosen as the basis for the bond factors, that same maturity should be used in adjusting the underwriting risk factors. For the illustrative rates, we have assumed that either 2 years or 5 years will be the final choice.

#### Average quality.

Working Group members previously expressed concern about tying the average quality assumed for this adjustment to the average quality of the investments actually held by health entities. Because of the covariance adjustment in the Health RBC formula, the impact of the bond factors will be diminished relative to the impact of the underwriting risk adjustment; higher yields from riskier bonds would therefore be likely to have a net favorable impact on RBC requirements, providing an undesirable incentive to lower the quality of investments held.

We agree that this is a reasonable concern. The best way to address it would be to base the adjustment on a high-quality rate. The rate could be a risk-free rate, for which U.S. Treasury securities yields would usually be considered a proxy. That may be unnecessarily conservative; a high-quality corporate bond rate, perhaps with a reduction

for expected defaults, might be a better option. For the illustrative rates, we present rates for both Treasury securities and single-A-rated corporate bonds.

#### Historical time period.

It would not be appropriate to use current rates. First, relatively few bond portfolios will have been invested entirely at current rates; investments will have been purchased over a series of years. Second, basing the adjustment on current rates would imply very frequent updates in the future.

One possibility is to tie the averaging period to the maturity assumption. In reality, a 2-year average maturity does not imply that the investments were purchased over the last two years; e.g., the portfolio could include a bond with 4 years to maturity that was purchased 6 years ago as a 10-year bond. However, as a matter of convenience, we can look at a 2-year average if the 2-year rate is being used, and a 5-year average if the 5-year rate is being used.

If a 2-year average is being used, the average could change significantly every year, and it would be necessary to monitor the average annually to determine if an update to the adjustment is needed. Even if a 5-year average is used, an adjustment might be necessary every 2 to 3 years. If the Working Group would prefer less frequent updates, a longer-term average should be used.

For the illustrative rates, we present averages over three periods for the Treasury rates and two periods for the single-A corporate rates (because of limitations on our corporate rate data set). For each average maturity, we present an average over the maturity period (2 or 5 years); a 10-year average; and a 30-year average.

#### Rounding.

There are two competing considerations with regard to rounding. On the one hand, rounding should be to a sufficient degree of precision that significant changes are not obscured. On the other hand, rounding should not be to such a high degree of precision that a change is indicated every time that the rate is re-evaluated.

Based on the tables in the Academy letter that show how the underwriting risk factors would vary with the assumed rate of investment return, we suggest that rounding to the nearest quarter of a percentage point (0.25%) would be appropriate. The change in the underwriting risk factor would be meaningfully large at such a degree of rounding, whereas smaller changes probably would not be.

If, over time, the Working Group concludes that rounding to the nearest 0.25% would result in the factors being updated too frequently, the rounding precision could be increased to 0.50%. However, we suggest beginning with 0.25%, and modifying that if necessary in the future.

To illustrate a currently reasonable range of rates, below we present rates for two maturities (2 years and 5 years), two quality categories (Treasury and single-A corporate), and three averaging periods (2/5 years, 10 years, and 30 years). The 30-year averaging period is shown only for Treasury securities, as our data source did not include the earlier years for single-A corporates; however, the difference between the 10-year and 30-year averages for single-A corporates can perhaps be inferred from the corresponding difference for Treasury securities. All averages are for periods ending 12/31/20.

	Average over <u>maturity period</u>	<u>10-year average</u>	<u>30-year average</u>
2-year maturity:			
Treasury	1.11%	0.70%	3.79%
A-rated corporate	1.55%	1.28%	
5-year maturity:			
Treasury	1.67%	1.45%	4.43%
A-rated corporate	2.29%	2.24%	

As can be seen, the appropriate assumption for the rate of investment return can vary widely, depending on which combination of options is decided upon. If a rounding precision of 0.25% is applied, then the rate of investment return would fall within the range of 0.75% to 4.50%.

The Academy letter.

We have only one comment with regard to the Academy letter. In the table on page 3 of the letter titled “Investment Income Adjusted Tiered RBC Factors,” the “high tier” factors should be rounded to two decimal places, just as the “low tier” factors are. There is no obvious reason to use a different degree of precision for the two sets of factors, and two decimal places give a better representation of the impact of the adjustment. We recommend that the Academy be asked for a re-rounded set of factors.

\* \* \* \* \*

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



James R. Braue  
 Director, Actuarial Services  
 UnitedHealth Group

cc: Crystal Brown, NAIC  
 Randi Reichel, UnitedHealth Group

## AHIP and BCBSA comments on Investment Income Adjustment



May 4, 2017

Mr. Steve Drutz  
 Chair, Health Risk-Based Capital (E) Working Group  
 National Association of Insurance Commissioners  
 1000 Walnut Street, Suite 1500  
 Kansas City, Missouri 64106-2197

RE: Capital Adequacy Task Force exposure of Health Risk Based Capital Working Group's proposal 2021-04-CA – Investment Income Adjustment in Underwriting Risk Factors

Dear Mr. Drutz:

America's Health Insurance Plans and Blue Cross and Blue Shield Association appreciate the opportunity to provide comments on the Health Risk-Based Capital (E) Working Group exposed proposal 2021-04-CA – Investment Income Adjustment in Underwriting Risk regarding the two options for an investment income adjustment to the H2 underwriting risk factors in the Health RBC formula.

We would also like to thank and express our appreciation to the Health Risk Based Capital Working Group ("Working Group") and the Academy of Actuaries ("Academy") for their work in the development of revised bond factors and incorporating an investment income adjustment into H2 Underwriting Risk calculation as we feel this was warranted.

Our comments regarding the proposed investment income adjustments in the underwriting risk are brief and our support is for Option 2 in the exposure.

The Academy in the development of the bond factors used a two-year time horizon and noted that a longer time horizon could be used based on the duration of assets held by health insurers. Additionally, the Academy developed bond factors for a five-year time horizon and the Working Group is completing a bond factor sensitivity analysis based on bond factors developed for both the two-year and five-year time horizons. On the surface one could assume similar time horizons would be used in the development of the H2 Investment Income Underwriting adjustment factor. In the Academy's December 15, 2020 letter to the Working Group regarding proposed H2 investment income adjustment factors, based those factors on claim payment completion patterns and investment income earned on premium less claims, or what is left after the timing of claim payment completion. Claim and expense payments for health companies are generally funded through routine ongoing cash receipts of premium. Any excess of premium after paying claims and expenses is held by companies to fund future cash needs or earmarked in surplus to support longer term needs like new business growth, operations, RBC capital

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requirements and future investments. Most of the underlying investments in health companies that support surplus are held in high quality fixed investments due to the conservative nature of health company investment policies. Historically, these bond investments have maturity dates longer than a claim payment cycle and have generated significant investment income over time to offset potential investment and underwriting risks that may be posed. Therefore, the longer time horizon in Option 2 is the more appropriate option of the two presented.

Additionally, we would recommend the development and use of a consistent transparent process to review and determine when factors should be adjusted to reflect changes in investment returns. We also recommend that ample lead time is given when any changes are proposed to allow health insurers the ability to adjust their capital and operating models to determine the impact from proposed changes. Extensive capital planning utilizing HRBC ratios is done to assure adequate capital is maintained as health plans price and grow their business and invest in strategic initiatives especially for the non-public health plans who have to support growth and strategic initiatives from operations.

Thank you in advance for your consideration of our comments and the continued work of the Health RBC Working Group and the Academy. If there are any questions about the comments submitted, please let us know. We look forward to further discussions related to this topic.

Ray Nelson  
Consultant to AHIP

Carl Labus  
Managing Director  
Blue Cross/Blue Shield Association

c/c: Crystal Brown, NAIC Staff  
Lou Felice, NAIC Staff

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

**CAPITAL ADEQUACY (E) TASK FORCE  
 WORKING AGENDA ITEMS FOR CALENDAR YEAR 2021**

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
<b>Ongoing Items – Health RBC</b>							
13	Health RBC WG	3	Year-end 2022 RBC or later	Evaluate the impact of Federal Health Care Law on the Health RBC Formulas	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula as a result of ongoing federal discussions and legislation. Adopted proposal 2020-02-CA	
14	Health RBC WG	3	Year-end 2022 RBC or later	Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales	HRBCWG	Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
<b>Carry-Over Items Currently being Addressed – Health RBC</b>							
15	Health RBC WG	3	Year-End 2023 RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA	
16	Health RBC WG	2	Year-end 2023 RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to Blanks (E) Working Group	
17	Health RBC WG	1	Year-end 2022 or later	Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks	HRBCWG	Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks.	8/4/2018

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

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**WORKING AGENDA ITEMS FOR CALENDAR YEAR 2021**

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
18	Health RBC WG	1	Year-end 2022 RBC or later	Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b.  Review Managed Care Credit across formulas.	HRBCWG	Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 & 1 to 2a and 2b.	12/3/2018
19	Health RBC WG	1	Year-end 2022 or later	Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
20	Health RBC WG	1	Year-End 2022 or later	Consider impact of COVID-19 and pandemic risk in the Health RBC formula.	HRBCWG		7/30/2020
21	Health RBC WG	1	Year-End 2021 or later	Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula.	HRBCWG	Referral Letter was sent to the Academy on Sept 21. Proposal 2021-04-CA	8/18/2020
22	Health RBC WG	1	2021	Discuss and determine the bond factors for the 20 designations.	Referral from Investment RBC July/2020	Working Group will use two- and five-year time horizon factors in 2020 impact analysis.	9/11/2020
<b>New Items – Health RBC</b>							
<b>23</b>	<b>Health RBC WG</b>	<b>1</b>	<b>Year-End 2022 or later</b>	<b>Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18 above)</b>	<b>HRBCWG</b>		<b>4/23/2021</b>