NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 2/15/2022

Virtual Meeting

HEALTH RISK-BASED CAPTIAL (E) WORKING GROUP
Friday, February 25, 2022
1:00 – 2:00 p.m. ET / 12:00 – 1:00 p.m. CT / 11:00 – 12:00 p.m. MT / 10:00 – 11:00 p.m. PT

ROLL CALL

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

NAIC Support Staff: Crystal Brown

AGENDA

1. Consider Referring Health Test Language Proposal to Blanks (E) Working Group—*Steve Drutz (WA)* — Attachment One
2. Consider Referring Letter to Health Actuarial (B) Task Force—*Steve Drutz (WA)* — Attachment Two
3. Consider Adoption of Proposal 2021-18-H-MOD—*Steve Drutz (WA)* — Attachment Three
4. Discuss Any Other Matters Brought Before the Working Group—*Steve Drutz (WA)*
5. Adjournment

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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

BLANK(S) TO WHICH PROPOSAL APPLIES

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

Anticipated Effective Date:

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Annual Statement Test language

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

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

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

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

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

12-16-21 – Exposed to the Health and Life Risk-Based Capital (E) Working Groups for 40 days.
1-5-22 – Revised Health Annual Statement Instructions – General Interrogatories – Line 2.1 – Premium Numerator for additional clarity.
1-27-22 – Revised the Life and P/C Annual Statement Instructions – General Interrogatories for the Reserve Numerator.
1-28-22 – Two comment letters received. Re-exposed to the Health and Life Risk-Based Capital (E) Working Groups for changes to the Reserve Numerator for 15 days. Comments due 2-14-22.
2-14-22 – No comments were received.

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

Health

GENERAL

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

1. **Health Statement Test:**

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

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

   Passing the Test:

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

   Failing the Test:

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

   Variances from following these instructions:

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

General Interrogatories

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

   All reporting entities should file the test.

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

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

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

Life, Accident and Health /Fraternal

Health Test

GENERAL

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

1. **Health Statement Test:**

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

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

   Passing the Test:

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

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

~~AND~~

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

~~AND~~

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

~~OR~~

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

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

Variances from following these instructions:

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

General Interrogatories

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

   All reporting entities should file the test.

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

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

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2.2	Premium Denominator	Premium and Annuity Considerations (Page 4, Line 1) of the reporting year's annual statement	Premium and Annuity Considerations (Page 4, Line 1) of the prior year's annual statement
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4(a)	Reserve Numerator	Net A&H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and Column 11 (excluding Dread Disease, Disability Income and Long-Term Care)) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Column 3 less 10, 11, 12 and Dread Disease included in Column 13) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)	Net A&H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and Column 11 (excluding Dread Disease, Disability Income, and Long-Term Care) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Column 3 less 10, 11, 12 and Dread Disease included in Column 13) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)
2.5	Reserve Denominator	Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)	Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

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

Property/Casualty

Health Test

GENERAL

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

1. **Health Statement Test:**

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

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

   Passing the Test:

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

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

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   ~~AND~~

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

   ~~AND~~

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

   ~~OR~~

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

   If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year

in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end.

Variances from following these instructions:

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

General Interrogatories

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

All reporting entities should file the test.

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

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	**Health Premium** values listed in the ~~statement value~~ Net Premiums Written column (Column ~~1~~4) of the reporting year's ~~P&C RBC report~~U&I Part 1B: Individual Lines: ~~Usual and Customary Major Medical and Hospital~~Comprehensive (hospital and medical) (individual and group) (Lines 13.1 and 13.2) Medicare Supplement (Line 15.4) Medicare Part D (Line 15.9, in part) Dental and Vision (Lines 15.1 and 15.2) Medicare (Line 15.6) Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Line 15.5) ~~Group Lines:~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ Stop Loss and Minimum Premium (Line 15.9, in part) ~~Dental and Vision~~ Federal Employee Health and Benefit Plan (Line 15.8)	**Health Premium** values as listed in the statement value column (Column 1) of the prior year's P&C RBC report: Individual Lines Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision Group Lines Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Stop Loss and Minimum Premium Dental and Vision Federal Employee Health and Benefit Plan
2.2	Premium Denominator	Premiums Earned (Page 4, Line 1) of the reporting year's annual statement	Premium Earned (Page 4, Line 1) of the prior year's annual statement
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4(a)	Reserve Numerator	Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only)) of the reporting year's annual statement.	Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only)) of the prior year's annual statement.
2.5	Reserve Denominator	Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the reporting year's annual statement.	Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year's annual statement.
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

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

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Commissioner Andrew N. Mais (CT), Chair of the Health Actuarial (B) Task Force and Fred Andersen (MN), Chair of the Long-Term Care Valuation (B) Subgroup

FROM: Steve Drutz (WA), Chair of the Health Risk-Based Capital (E) Working Group

DATE: Feb. 25, 2022

RE: AG 51 – Asset Adequacy Testing

The Health Risk-Based Capital (E) Working Group established the Health Test Ad Hoc Group in 2018 to review the health test language within the *Annual Statement Instructions* due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Currently, a company passes the health test if the following requirements are met:

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

  AND

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

  AND

- At least 75% of the entity's current year premiums are written in its domiciliary state.

  OR

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

The intent of the Ad Hoc Group was to evaluate if changes were warranted to the health test because of industry changes since its original development. The Ad Hoc Group has drafted a phase 1 proposal that will delete the requirements for an entity being licensed and actively issuing and/or renewing business in five states or less and at least 75% of the entity's current year premiums being written in their domicile state. The Ad Hoc Group is continuing to evaluate the current 95% premium and reserve ratios.

Through the evaluation and discussion of the 95% reserve ratio, there was a question brought up as to whether an entity would still be required to perform asset adequacy testing of long-term care (LTC)

business if the entity moved from the life blank to the health blank. It is the Ad Hoc Group's understanding that asset adequacy testing is required, regardless of the blank if the criteria for asset adequacy testing are met. The Working Group is asking the Health Actuarial (B) Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that would indicate that regardless of the blank the entity files, asset adequacy testing is required by the entity if the criteria are met.

This clarification would help to make it abundantly clear that all companies with LTC exposure that are subject to asset adequacy testing would still be required to meet these requirements, regardless of the blank they are filing on.

If you have any questions regarding the suggested clarification, please contact Crystal Brown.

Capital Adequacy (E) Task Force

RBC Proposal Form

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

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

FOR NAIC USE ONLY

Agenda Item # 2021-18-H-**MOD**
Year 2022

DISPOSITION

[ ] ADOPTED _____
[ ] REJECTED _____
[ ] DEFERRED TO _____
[ ] REFERRED TO OTHER NAIC GROUP
[x] EXPOSED Dec. 3, 2021
[ ] OTHER (SPECIFY) _____

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

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

DESCRIPTION OF CHANGE(S)

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

REASON OR JUSTIFICATION FOR CHANGE **

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

Additional Staff Comments:

11-4-21 cgb The WG exposed for 30-day public comment period ending on Dec. 3, 2021.
12-16-21 cgb One comment letter received.
12-16-21 cgb The Working Group adopted the proposal.
01-28-22 cgb The Working Group re-exposed with alternative language for 15 days. Comments due back on 02-14-22.
02-14-22 cgb No comments received.

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

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

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

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 0.5%.

	$0 – $3 Million	$3 – $25 Million	Over $25 Million
Comprehensive Medical & Hospital	0.1493	0.1493	0.0893
Medicare Supplement	0.1043	0.0663	0.0663
Dental & Vision	0.1195	0.0755	0.0755
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. The Working Group will evaluate the yield of the 6-month Treasury bond as of January 1st each year and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

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

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Alternative Language:

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

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