Draft date: 2/4/26

Virtual Meeting

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP
Friday, February 13, 2026
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	Margaret Otto	Nebraska
Danielle Smith, Vice Chair	Missouri	Michel Laverdiere	New York
Wanchin Chou	Connecticut	Diana Sherman	Pennsylvania
Kyle Collins	Florida	Bing Wu	Texas
Tish Becker	Kansas		

NAIC Committee Support: Derek Noe/Maggie Chang

AGENDA

1. Consider Adoption of its Nov. 6, 2025, Minutes—*Steve Drutz (WA)* — Attachment 1

2. Receive Comments on a Referral from the Risk-Based Capital Investment Risk and Evaluation (E) Working Group—*Steve Drutz (WA)*
   A. PineBridge Investments — Attachment 2
   B. Premera Blue Cross — Attachment 3

3. Receive Comments on Proposal 2025-15-CA—*Steve Drutz (WA)* — Attachment 4
   A. AHIP — Attachment 5
   B. Blue Cross Blue Shield Association (BCBSA) — Attachment 6
   C. UnitedHealth Group (UHG) — Attachment 7

4. Receive Comments on the Managed Care Credit Draft—*Steve Drutz (WA)*
   A. AHIP
   B. BCBSA
   C. CJW Associates — Attachment 8
   D. UHG — Attachment 9

5. Discuss H-2 Risk Factor Implementation—*Steve Drutz (WA)*

6. Discuss its Letter to the American Academy of Actuaries (Academy) —*Steve Drutz (WA)* — Attachment 10

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

8. Adjournment

Draft: 11/12/25

Health Risk-Based Capital (E) Working Group
Virtual Meeting
November 6, 2025

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Nov. 6, 2025. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair (TX); Wanchin Chou (CT); Kyle Collins (FL); Sarah Smith (KS); Danielle Smith (MO); and Margaret Otto (NE).

1. Adopted Sept. 29 and June 20 Meeting Minutes

The Task Force met Sept. 29 and June 20. During its Sept. 29 meeting, the Working Group took the following action: 1) discussed comments received on the American Academy of Actuaries' (Academy's) H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital (RBC) Formula Report; 2) discussed the impact analysis of factors and structure from the Academy's H2 report; and 3) exposed a referral from the Risk-Based Capital Investment Risk and Evaluation (E) Working Group. During its June 20 meeting, the Working Group took the following action: 1) adopted its April 30 and Spring National Meeting Minutes; and 2) discussed the 2024 health RBC statistics.

Chou made a motion, seconded by Smith, to adopt the Task Force's Sept. 29 (Attachment One-A) and June 20 (*see NAIC Proceedings – Summer 2025, Capital Adequacy (E) Task Force, Attachment Three*) minutes. The motion passed unanimously.

2. Adopted its Revised 2025 Working Agenda

Drutz said the next agenda item was to update the Working Group's working agenda for 2025. He stated that changes to the working agenda were identified using track changes and included the following edits: 1) line X1 was updated to reference the adoption of proposal 2025-03-CA; 2) a previous H2 working agenda item was split into lines X4, X5, and X6 to align with the three work products from the Academy report (i.e., the H2 structure, H2 factors, and managed care credit expansion); 3) line X8 was added to address the Statutory Accounting Principles (E) Working Group referral on moving some non-bond debt to Schedule BA as a result of the principles based bond project; and 4) line X9 was added because the Working Group decided to take up the long-term care topic.

Smith made a motion, seconded by Chou, to adopt the Working Group's 2026 working agenda (Attachment Six). The motion passed unanimously.

3. Exposed Proposal 2025-15-CA (A&H Underwriting Risk Structure Change)

Drutz said the Academy presented its H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health RBC Formula Report to the Working Group during its April 30 meeting. The report included a revised structure to more closely align the underwriting risk pages with the lines of business as presented in the analysis of operations of the Health Annual Statement. The report also advised changing the implementation in the life and property/casualty RBC to mirror the line of business changes in the health RBC. The proposal incorporates the proposed changes to the underwriting risk structure found on XR013, LR020, and PR020, as well as the removal of the two times individual risk from the alternate risk charge.

Drutz said a few tables were truncated in the materials and asked committee support what was missing. Committee support said the lines for dental, vision, and stand-alone Medicare Part D were truncated but would be available in full and posted for exposure.

Drutz noted that the proposal was only the structure for the underwriting risk pages. He asked if there were any objections to exposing the proposal. Drutz noted that the exposure would be mentioned to life, health, and P/C working groups during their respective meetings to ensure they are all aware.

Hearing no objections, the Working Group exposed the proposal for a 75-day comment period ending Jan. 20, 2026.

4. Requested Comments on the Conceptual Draft for Managed Care Credit

Drutz said the Academy's H2—Underwriting Risk Component and Managed Care Credit Calculation in the health rbc formula report proposed collecting additional information on managed care credit contracts to align with new forms utilized in the industry. Industry members commented on the report and inquired whether the new information could be collected at the line-of-business level. The draft contained possible instructions and tables to collect the information on a line-of-business basis. He said the draft would be exposed to receive comments from interested parties so the Working Group could develop a proposal for the Blanks (E) Working Group.

Drutz asked if there were any objections to exposing the draft. Hearing no objections, the proposal was exposed for a 75-day comment period ending Jan. 20, 2026.

5. Discussed Other Matters

Drutz reminded attendees that the Working Group will not meet at the Fall National Meeting. He also reminded attendees that the Working Group has an exposed referral with comments due Dec. 3.

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

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/CADTF/2025_3Fall/CADTF/11_19/HRBC/AttE_11_06_25_HRBC_Interim%20Meeting%20Minutes%20TPRd.docx

PineBridge® INVESTMENTS

September 29, 2025

TO: NAIC Health Risk-Based Capital (E) Working Group ("Health RBC WG")
CC: NAIC Risk-Based Capital Investment Risk and Evaluation (E) Working Group ("IRE WG"); Valuation of Securities (E) Task Force

Subject: Harmonization of RBC Treatment for Investment Funds for Health Insurers

Dear Chair and members of Health Risk-Based Capital (E) Working Group,

We commend the NAIC for its continued efforts to align the Risk-Based Capital ("RBC") treatment of investment funds. We are grateful to the Health RBC WG for addressing the referral from the IRE WG regarding the harmonization across life and non-life insurers.

We appreciate the time and effort the NAIC has dedicated to this important issue. Over the last decade, investment funds have increasingly enabled insurers to access a broader and more diversified range of asset classes, many of which were previously difficult for insurers to access, especially smaller insurers. Notable examples include insurer participation in loan markets and infrastructure projects, which are now more accessible through fund structures due to their operational efficiencies and diversification benefits.

The initiative to harmonize RBC treatment for funds aligns funds risk assessment with the NAIC's Securities Valuation Office ("SVO") designation and supports certain NAIC guiding principles:

- **Substance Over Form**: Regardless of the legal form (e.g., ETF, mutual fund, or private fund), if the underlying portfolio carries the same investment risk as measured by SVO designation, the RBC charge should be applied consistently.
- **Equal Capital for Equal Risk**: RBC charges for fixed income funds should reflect the credit risk of the aggregate underlying portfolio on a look-through basis. Accordingly, fixed income funds should receive bond-like RBC treatment.

The NAIC noted that non-life insurers currently face more conservative RBC charges for funds; and non-life insurers, if aligned with life insurers, would have the option to use SVO designation for RBC relief at their discretion.[1] Specifically,

- **Mutual funds and private funds with an existing designation**. A non-life insurer would apply a bond-like RBC commensurate with the SVO designation, which is more accurate than the existing framework that assigns a flat 15% or 20% RBC charge. We also believe covariance adjustments do not fully mitigate the current punitive RBC charges to these funds.
- **Other funds.** If a fund lacks an SVO designation, the insurer or the fund manager may seek one. If no action is taken, the existing RBC charge remains unchanged and conservatively applied.

[1] The NAIC RBC IRE Working Group June 23, 2025 meeting minutes stated "filers potentially face more conservative capital charges," and "filing with the SVO is optional, and the proposal for life insurers is to allow risk charges commensurate with the risk as represented by the SVO designations."

- **Asset Concentration Factor**. Applying look-through treatment for asset concentration, consistent with the life insurance industry's implementation proposal, would also be beneficial for non-life insurers.

Sincerely yours,
PineBridge Insurance Solutions and Strategies

PREMERA | BLUE CROSS

Attachment 3

Premera Blue Cross
PO Box 327 – MS 341
Seattle, WA 98111-0327

NAIC
1101 K Street, N.W., Suite 650
Washington, DC 20005

August 5, 2025

Dear Chair and members of Property and Casualty Risk-Based Capital (E) Working Group (Health Risk-Based Capital (E) Working Group),

While we support the principle of developing a proposal for harmonization that includes assigning bond-like treatment to SVO designated funds, we urge the Working Group to expand this from Life companies only to all insurer types.

Industry research notes that 96% of SVO-designated mutual funds and a significant amount of private funds reside on non-life insurance balance sheets. However, for fixed income funds, as a P&C insurer, presently we are subject to punitive RBC charges, i.e., Schedule D-2 Equity charge to mutual funds and Schedule BA charge to private funds. At the same time, Life insurers have been benefiting from bond-like treatment for SVO designated private funds and will likely be able to apply the same to mutual funds given the exposure draft. This inconsistency disadvantages us as a P&C (Health).

There are capital efficiency considerations to our investment decisions. We utilize fund vehicles such as ETFs and mutual funds for certain fixed income exposures due to their liquidity, diversification, operational and expense efficiencies. We also invest in private funds for access to other types of private fixed income exposure. In our view, the ability to invest in fixed income funds and to receive fair RBC treatment commensurate with the associated SVO designation is critical for leveling market access. This is primarily true for smaller insurers, where cost or complexity issues render funds as the only reasonable vehicle, but also impacts larger insurers seeking to access more niche strategies for similar benefit.

In our opinion, this movement furthers the guiding RBC principle of "equal capital for equal risk" and agrees with the recent Principles-Based Bond Definition initiative that stressed "substance over form." Aligning these metrics improves solvency assessments for all insurance lines, not just Life companies where this has been exposed.

Sincerely,

David Ratliff, CFA
VP, Treasury & Investments

601 Pennsylvania Avenue, NW
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Washington, D.C. 20004

T 202.778.3200
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ahip.org

January 29, 2026

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

Via email: Derek Noe, dnoe@naic.org
Maggie Chang, mchang@naic.org
Steve Drutz, steve.drutz@oic.wa.gov

Re: Exposures of 2025-15-CA A&H Underwriting Risk Structure Change and Managed Care Credit Concept Draft

Dear Mr. Drutz:

On behalf of the members of AHIP[1], we appreciate the opportunity to provide comments on the above referenced items that were exposed during the Working Group's meeting held on November 6, 2025.

AHIP is appreciative of the significant work done to date on this complex project by the Working Group, NAIC Staff, and the American Academy of Actuaries. Following are our comments on the exposures:

Proposal 2025-15-CA A&H Underwriting Risk Structure Change

1. XR013 Instructions – working on page 1:
    - Under 'Claims Experience Fluctuation', the existing wording in Section B for the alternate risk charge regarding multi-line organizations appears to be inconsistent with the later instructions for Lines 17-19. The language regarding offsets (as well as the cap amounts) and the charge not being cumulative for each line do not match up with the subsequent instructions.

- For consistency, the word ‘alternative’ should to be changed to ‘alternate’ when referring to the risk charge. This would be consistent with the subsequent instructions as well as page XR013 which refers to ‘alternate risk charge’.

2. XR013 Instructions – wording on page 2: In Column (1) instructions there are multiple existing sentences about what is not included in this category. We believe these sentences also apply to the other Columns on this page. These sentences should be moved to the first paragraph, in order to apply to all Columns.
3. XR013 Instructions – page 6: The instructions for Line 17 Alternate Risk Charge appear to require the Alternate Risk Charge whether or not a company has business in a particular product line. A modification is recommended to note that in the event a company does not have business in a particular product line column, the Alternate Risk Charge should be zero.
4. XR013 Instructions – page 6: In the instructions for Line 18 Net Alternate Risk Charge, is it intended that only columns 5-8 receive offsets from other business lines? In addition, should there be instructions for Column (9) included in the Line 18 instructions?

<u>Managed Care Credit Concept Draft</u>

5. Draft Instructions:
    - It appears that the existing instructions apply to Exhibit 7 – Part 1 and that the new draft contains instructions for Part 1B.
        i. Should the Part 1 instructions for lines 1-6 be repeated in Part 1B?
        ii. Should definitions for lines 11-15 be included in Part 1B?
    - All instructions should be as clear as possible to ensure uniform data collection among companies. For example, the term ‘prior year’ is included in many of the instructions. Does ‘prior year’ mean the year prior to the statement year? This clarification should be made.
6. Exhibit 7 – Part 1B: It should be noted that Table 1 is labeled as ‘Direct’, Table 2 as ‘Ceded’ and Table 3 as ‘Net’. Is Table 3 intended to be Table 1 less Table 2? However, since Assumed business is not reflected, Table 3 may not truly be ‘Net’. AHIP is not recommending that Assumed business be included as we do not believe that these splits will necessarily be available for Assumed business. As this data is for analysis purposes only

and does not impact RBC, we believe that the 'Net' data being 'Direct' less 'Ceded' is all right for these purposes.

7. Please note that the availability of the additional data splits contained in the Part 1B tables vary from company to company. Changes may be needed for many companies to track the requested data. As such, AHIP suggests language be added to allow for companies to apply reasonable estimation methods in instances where the exact data is not readily available.

Thank you for the opportunity to provide these comments. We look forward to continuing to work with the Health Risk-Based Capital (E) Working Group on these matters in the future.

Sincerely,

LaCosta Wix
AHIP Senior Regulatory Counsel
State Affairs and Policy

Cc: Miranda Motter, AHIP Senior Vice President of State Affairs and Policy
Raymond Nelson, AHIP Consultant

January 20, 2026

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

By Email to: Steve Drutz at steve.drutz@oic.wa.gov, Derek Noe at dnoe@naic.org, and Maggie Change at mchang@naic.org

Re: Exposures 2025-15-CA A&H Underwriting Risk Structure Change and the Managed Care Concept Draft

Dear Mr. Drutz:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to comment on Exposure 2025-15-CA A&H Underwriting Risk Structure Change and the Managed Care Concept Draft. BCBSA continues to support the work of the Health Risk Based Capital Working Group (HRBCWG) in their efforts to revise the H2-Underwriting Risk section of the Health Risk Based Capital formula.

BCBSA is a national federation of 33 independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own. BCBSA has long advocated for commonsense solutions to ensure a robust, competitive private marketplace that offers individuals a broad range of choices to meet their needs at the best possible price. We appreciate the HRBCWG efforts to revise the H2-Underwriting Risk section of the Health Risk Based Capital formula. Our comments, which follow below, relate to the Health Risk Based Capital formula and are more editorial in nature regarding potential instruction or exhibit clarifications and/or questions.

1. **Column (1) Comprehensive (Hospital & Medical) Individual instructions**. These instructions refer to the exclusion of administrative services contracts, administrative services only contracts, or any non-underwritten business along with an exclusion for FEHBP and TRICARE. Should those exclusions be included in the Comprehensive (Hospital & Medical) Group instructions for consistency where the exclusions may be more relevant?

2. **Page XR013 the Cell A1 and A2 formulas reference Line (1) in the calculations**. Should that reference be Line (10)?
3. **The Managed Care Credit Concept Draft instructions reference prior years for certain lines**. We presume that it is the prior reporting year after contracts are settled. So, for 2026 calendar year reporting, we would report the 2025 year. Is that correct?
4. **The Managed Care Credit Concept Draft Exhibit 1-Part 1B excludes a table for assumed business when determining the Net Medical Expense Payments**. We presume the assumption is that transactions with providers will not be available on assumed business, which may be the case or difficult to obtain. Therefore, the current tables may be appropriate for developing revised managed care credit criteria.
5. **The new line categories on Exhibit 1-Part 1B may require reporting changes initially for companies to report accurately and consistently**. We ask the working group to take this into consideration and allow estimates and the best judgement of appropriate reporting for the new categories in the initial reporting period for 2026.

We appreciate your consideration of our comments. If you have any questions or want additional information, please contact **Carl Labus**, Principal Analyst, Plan Financial Services, at carl.labus@bcbsa.com.

Sincerely,

Clay S. McClure
Senior Director, State Affairs
Blue Cross Blue Shield Association

UNITEDHEALTH GROUP

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

January 20, 2026

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 Derek Noe.

Re: Proposal 2025-15-CA.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group with regard to Proposal 2025-15-CA, as exposed for comment by the Health Risk-Based Capital (E) Working Group ("Working Group") on November 6, 2025. The first section of this letter addresses some issues regarding the Alternate Risk Charge. The second section contains our recommendations for clarifications and corrections to the exposed language.

Alternate Risk Charge.

The Alternate Risk Charge in Proposal 2025-15-CA differs significantly from what was proposed by the American Academy of Actuaries in their April 2025 report, "H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula Report." The Academy's report continued the current approach of assigning a specified minimum risk charge to each line of business, and then taking the maximum of those amounts across all lines of business as the Alternate Risk Charge.

Proposal 2025-15-CA, in contrast, assigns a smaller minimum risk charge ($500,000 vs. $1,500,000) to each of the "comprehensive" lines of business (Comprehensive Individual, Comprehensive Group, Medicare, and Medicaid), and then sums the relevant amounts to create a minimum risk charge for those lines in aggregate. Whereas the Academy's proposal would have created an Alternate Risk Charge of $1,500,000 if a reporting entity wrote any of the comprehensive lines of business, Proposal 2025-15-CA would create an Alternate Risk Charge

ranging between $500,000 and $2,000,000 depending on the number of the comprehensive lines written by that entity.

The reason for this deviation from the Academy's original proposal is not clear to us, and we would welcome an explanation from either the Working Group or Academy staff.

We also note that the formulas for B1, B2, and B3 on pages 48, 57, and 69 are misleading. As written, the formulas suggest that the Alternate Risk Charges for the non-comprehensive lines of business apply regardless of whether the reporting entity actually writes those other lines of business. The descriptive language on pages 8, 29, and 44 could be interpreted as supporting that same approach. We feel certain that this does not represent the actual intent of the Working Group, but care should be taken that the eventual coding of the adopted formulas does not inadvertently maintain that inappropriate treatment.

Recommended clarifications and corrections.

Recommendations below are listed according to the page of Proposal 2025-15-CA on which the relevant material appears.

Page 3: The paragraph labeled "B" does not match the Alternate Risk Charge approach that is specified in the proposal. If that approach is retained, paragraph B should be revised as follows.

> B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge~~maximum retained risk (level of potential claim exposure)~~ is ~~capped at~~ $500,000 per line for medical coverage~~,~~, $50,000 total for all other coverage except Medicare Part D coverage, and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (i.e~~e.g.~~, writing more than one coverage type), the total alternative risk charge is the highest of the cumulative alternative risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Vision Only, Dental Only); Medicare Part D; and Other Health. For example, if an organization writes Comprehensive – Individual, Comprehensive – Group, Vision Only, and Dental Only, the alternative risk charge is $1,000,000 (the cumulative charge for Comprehensive – Individual and Comprehensive – Group, which is higher than the $100,000 cumulative charge for Vision Only and Dental Only. ~~for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive (hospital & medical) individual & group (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).~~

Page 4: The header on this page says "L(1) through L(20)," but in fact there are only 19 lines in the proposed version of XR013.

The comment in the Column (1) instructions about excluding ASC/ASO business actually applies to all of the lines of business. It should be moved to a position before the instructions for

the separate columns. Likewise, the comment about including prescription drug benefits applies to multiple lines of business, and should be moved to a similar position.

The instructions for Column (1) also say, "Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 24 of this section." In the proposed structure, FEHBP and TRICARE are actually addressed on Line (22).

The instructions for Column (6) and Column (7) refer to "Vision" and "Dental"; however, the column headings on XR013 are actually "Vison Only" and "Dental Only" (although the subsidiary tables for the Alternate Risk Charge and the Initial Premium Amount use "Vision" and "Dental"). There are similar differences in terminology throughout the instructions and the formula pages. We suggest that the naming convention for those lines of business be made consistent throughout.

Page 5: The instructions for Column (9) say, "Stop-loss premiums are addressed separately in Line (25) on page XR015." The correct line reference is Line (23).

The instructions for Line (1) Premium say, "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." Note that for Medicaid and Medicare business, premiums may also be received from state agencies or from CMS, not only from the covered group or individual.

The instructions for Line (5) Net Incurred Claims say, in regard to Stand-Alone Medicare Part D, "report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR015." The correct line reference is Line (24.1).

Page 6: In the instructions for Line (12), and throughout the instructions and blanks pages, the term "Income Adjustment Factor" should be "Investment Income Adjustment Factor," for the sake of clarity. (Or, if something briefer is desired, even "Investment Income Factor" would do.) Note that in the Property Casualty RBC formula, the line for the comparable adjustment is captioned, "Adjustment for Investment Income."

Also, in the instructions for Line (13), the comment about the investment yield probably should be deleted. If the yield is stated at all, it should be in the instructions for Line (12).

Page 20: In the instructions for Line (32), item (b), the line references should be to Line (32) rather than Line (31).

Page 24: The paragraph labeled "B" has been edited to give only a very brief description of the Alternate Risk Charge. For the sake of clarity, some consideration should be given to adding the full language suggested above in our comments on p. 3.

Page 27: While the caption "Line (12) Income Adjustment Factor" appears on this page, no description of that line is actually given. We recommend that the description from p. 6 be inserted here. (This also applies to the PR020 instructions on p. 43.)

Page 40: In the first paragraph under the heading "Line (1) through Line (19)," the number of relevant lines of business has been updated from four to eight in the first sentence, but not in the third sentence. The third sentence should be updated accordingly.

Page 41: In the instructions for Line (4) Underwriting Risk Revenue, the reference to Line (1.3) has been revised to Line (1). However, the structure of PR020 as shown on p. 68 indicates that Line (1.3) is still the correct reference, and should be restored.

Page 46 (XR013): It appears that in Column (10), Line (6) should contain "XXX" rather than being blank. Is there any reason there would ever be an amount there?

Also, since there is no Managed Care Discount Factor applicable to Other Health, it seems that in Column (9), Line (15) should contain "XXX" rather than being blank.

There apparently was supposed to be a footnote, as indicated by the double-dagger, to the section listing the Initial Premium Amount for each category of business; however, the footnote is not included on the page. (This also applies to p. 55, LR020, and p. 68, PR020.)

Page 48: In the formulas for A1 and A2, the references to Line (1) should actually be to Line (10). (This also applies to pp. 57 and 69.)

Page 49 (XR015): For Line 24.3, the source is given as "Sum of Lines (21) through (24.2)." The sum actually begins with Line 20, not Line 21.

Page 51 (XR017): The caption for Line (41.1) should reference Line (41), not Line (42).

The captions for Lines (42.1) and (42.2) should reference Line (42), not Line (43), and the captions for Lines (42.4) and (42.5) should reference Lines (42.3) and (42.4) respectively, rather than Lines (43.3) and (43.4).

In the footnote indicated by Φ, the description "XR013, Column (11), Line (21) Less Column (8)" should read "XR013, Column (11), Line (19) Less Column (8), Line (19)".

Page 54 (LR019): Line 1, Comprehensive Medical and Hospital, should be split into separate lines for Individual and Group. (This also applies to p. 67, PR019.)

The † footnote indicates which types of business require the completion of the Health Administrative Risk portion of LR029. This footnote was updated to reflect the new line numbers on LR019. However, the revised note includes Stand-Alone Medicare Part D among the business that is subject to the Health Administrative Risk calculation, whereas Stand-Alone Medicare Part D is not included in the current version of the note. While we do not necessarily disagree with this change, we would be interested in the reasoning behind including it in this proposal. Was it considered essentially a correction rather than a change in intention?

Page 55 (LR020): Now that Individual and Group business are in separate columns, Lines 1.1, 1.2, and 1.3 can be collapsed into one line. (This also applies to p. 68, PR020.)

Also note that in the table at the bottom for the Initial Premium Amount, the amounts shown are actually the Alternate Risk Charge amounts.

* * * * *

Thank you for the opportunity to provide these comments. We would be happy to discuss these comments with you and the Working Group.

Sincerely,

James R. Braue
Vice President, Actuarial Services
UnitedHealth Group

cc: Derek Noe, NAIC
Alena Yankouskaya, UnitedHealth Group
Mollie Zito, UnitedHealth Group

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 ☐ P/C RBC (E) Working Group ☐ Longevity Risk (A/E) Subgroup
☐ Variable Annuities Capital. & Reserve (E/A) Subgroup ☐ Economic Scenarios (E/A) Subgroup ☐ RBC Investment Risk & Evaluation (E) Working Group

DATE: 11/4/2025	**FOR NAIC USE ONLY**
CONTACT PERSON: Derek Noe	Agenda Item # 2025-15-CA-MOD
TELEPHONE: 816-783-8973	Year 2026
EMAIL ADDRESS: dnoe@naic.org	**DISPOSITION**
ON BEHALF OF: Health Risk-Based Capital (E) Working Group	**ADOPTED:**
NAME: Steve Drutz	☐ TASK FORCE (TF) _____
TITLE: Chief Financial Analyst/Chair	☐ WORKING GROUP (WG) _____
AFFILIATION: WA Office of Insurance Commissioner	☐ SUBGROUP (SG) _____
ADDRESS: 5000 Capital Blvd SE	**EXPOSED:**
Tumwater, WA 98501	☐ TASK FORCE (TF) _____
	☒ WORKING GROUP (WG) 2/13/2026
	☐ SUBGROUP (SG) _____
	REJECTED:
	☐ TF ☐ WG ☐ SG _____
	OTHER:
	☐ DEFERRED TO _____
	☐ REFERRED TO OTHER NAIC GROUP
	☐ (SPECIFY) _____

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

☒ Health RBC Blanks ☒ Property/Casualty RBC Blanks ☒ Life and Fraternal RBC Blanks
☒ Health RBC Instructions ☒ Property/Casualty RBC Instructions ☒ Life and Fraternal RBC Instructions
☒ Health RBC Formula ☒ Property/Casualty RBC Formula ☒ Life and Fraternal RBC Formula
☐ OTHER _____

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

Changes to the structure of pages XR013, XR014, PR019, PR020, PR022, PR025, LR019, and LR020 based on the recommendations from the Academy's H-2 Underwriting Risk Report.

The Academy presented their *H2-Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula Report* to the Health Risk-Based Capital Working Group at their April 30, 2025 meeting. The report presented a revised structure to more closely align the underwriting risk pages with the lines of business as presented in the Analysis of Operations of the Health Annual Statement. The report also advised to change the implementation in the Life and Property and Casualty RBC to mirror the line of business changes in Health.

This proposal also implements a new alternative risk charge based on the recommendation from the Academy that the multiple of maximum individual risk be eliminated.

Additional Staff Comments:

LR029 Line (42) and PR022 Line (5) now include Title XVIII Medicare and Title XIX Medicaid as part of total health premium.

Income adjustment factor instructions and values will be updated during the annual Investment Income Adjustment review.

02/10/26 Revisions

Changes are highlighted in yellow.

Changed numeric references in the health instructions and blanks to match the renumbered lines.

Updated line reference for PR019 to match renumbered lines.

Added description to the PR020 and LR020 line 12 instructions.

Changed verbiage in the instructions for the Alternate Risk Charge

Did not remove lines 1.1, 1.2, and 1.3 from PR020 and LR020 as those lines are used for calculations on other pages. LR019 individual and Group comprehensive were already separated.

**** This section must be completed on all forms.** **Revised 2-2023**

UNDERWRITING RISK - L(1) THROUGH L(1921)

XR013

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

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

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

Claims Experience Fluctuation

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

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

or

B. An alternat~~ive~~ 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 alternate risk charge ~~maximum retained risk (level of potential claim exposure)~~ is ~~capped at $750,000 per individual and~~ $~~1,~~500,000 per line ~~total~~ for medical coverage,~~;~~ ~~$25,000 per individual and~~ $50,000 each~~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 (i.e.~~e.g.~~, writing more than one coverage type), the total alternat~~ive~~ risk charge is the highest of the cumulative alternate risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Dental only, Vision Only); Medicare Part D; and Other Health. For example, if an organization writes Comprehensive – Individual, Comprehensive – Group, Vision Only, and Dental Only, the alternate risk charge is $1,000,000 (the cumulative charge for Comprehensive – Individual and Comprehensive – Group, which is higher than the $100,000 cumulative charge for Vision Only and Dental Only.)~~for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive (hospital & medical) individual & group (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).~~

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

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

L(1) through L(1921)

There are tensix lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive (Hospital & Medical) individual & group; (2) Comprehensive (Hospital & Medical) group; (3) Title XVIII Medicare; (4) Title XIX Medicaid; (52) Medicare Supplement; (63) Dental/Vision Only; (7) Dental Only; (84) Stand-Alone Medicare Part D Coverage; (95) Other Health; and (106) 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. These categories DO 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. The descriptions of the items are described as follows:

Column (1) – Comprehensive (Hospital & Medical) Individual & Group. Includes policies providing for medical coverages including hospital, surgical, and 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 does not include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 224 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) – Comprehensive (Hospital & Medical) Group Includes policies providing for medical coverages including hospital, surgical, and major medical. Prescription drug benefits included in major medical insurance plans should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Column (3) – Title XVIII Medicare 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

Column (4) – Title XIX Medicaid Business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers.

Column (52) – 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 (Hospital & Medical) Individual & Group.under Title XVIII Medicare.

Column (63) – Dental & Vision Only. 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 (7) – Dental Only This is limited to policies providing for dental-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 (84) – Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR015. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

Column (95) – Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, that have not been specifically addressed in Columns (1) through (84) listed above and those lines of business addressed separately on page XR015, such as stop loss. Stop-loss premiums are addressed separately in Line (235) on page XR015.

Column (106) – 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, CMS, or state agency 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 (24) 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 (35) 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 (46) Underwriting Risk Revenue. The sum of Lines (1) ~~through~~ and (24) minus Line (35).

Line (57) 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 Benefits 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 (245.1) of page XR015.

Line (68) 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 (710) 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 (811) Underwriting Risk Incurred Claims. Line (59) minus Lines (610) and (7).

Line (912) Underwriting Risk Claims Ratio. For Columns (1) through (95), Line (811)/Line (46). If either Line (46) or Line (811) is zero or negative, Line (912) is zero.

Line (10) Underwriting Risk Factor for Initial Amounts of Premium. Factor applied to the first $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to the first $3,000,000 in premium for columns (5), (6), (7),

Line (11) Underwriting Risk Factor for Excess of Initial Amount. Factor applied to premium in excess of $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to premium in excess of $3,000,000 in premium for columns (5), (6), (7),

Line (12) Investment Income Adjustment Factor. The investment income yield was incorporated into the Comprehensive (Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned

by the insurer. The Working Group incorporated a 4.5% income yield that was based on the yield of a 6-month U.S. Treasury bond. Each year, the Working Group will identify the yield of the 6-month U.S. Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modification to the 4.5% adjustment is needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (13) Composite Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (46), Underwriting Risk Revenue. Includes the Investment Income Adjustment Factor ~~The factors for Column (1) through (3) have incorporated an investment income yield of 4.5%.~~

	~~$0 – $3 Million~~	~~$3 – $25 Million~~	~~Over $25 Million~~
~~Comprehensive (Hospital & Medical) Individual & Group~~	~~0.1440~~	~~0.1440~~	~~0.0844~~
~~Medicare Supplement~~	~~0.0987~~	~~0.0609~~	~~0.0609~~
~~Dental & Vision~~	~~0.1153~~	~~0.0716~~	~~0.0716~~
~~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 (Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month U.S. Treasury bond. Each year, the Working Group will identify the yield of the 6-month U.S. Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modification to the 4.5% adjustment is needed. Any adjustments will be rounded up to the nearest 0.5%.~~

Line (14) Base Underwriting Risk RBC. Line (46) x Line (9~~12~~) x Line (13).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line (178) 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.~~ $500,000 for Columns (1), (2), (3), and (4); $50,000 for Columns (5), (6), (7), and (9); and $150,000 for Column (8).

~~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 (1820) 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.~~ The alternate risk charge is $500,000 per line for medical coverage, $50,000 total for all other coverage except Medicare Part D coverage, and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (i.e., writing more than one coverage type), the total alternate risk charge is the highest of the cumulative alternate risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Dental only, Vision Only); Medicare Part D; and Other Health.

Line (2119) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (1820) for each of columns (1) through (95). This is the amount in Line (14) for. Column (610). The amount in Column (117) is the sum of the values in Columns (1) through (106).

OTHER UNDERWRITING RISK – L(202) THROUGH L(445)

XR015–XR017

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

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the Federal Employees Health Benefit Program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by 2% to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive (Hospital & Medical) individual & group or Other Health Coverages (Page XR013). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35% will be applied to the first $25,000,000 in premium and a factor of 25% will be applied to premium in excess of $25,000,000. Stop-loss premiums should be reported on a net basis.

Line (245.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in INT 05-05: Accounting for Revenue under Medicare Part D Coverage) for the incurred claims associated with the beneficiaries for these supplemental drug benefits.

Line (245.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital (E) Working Group, however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2% factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR013, Column (41), Line (35).

Lines (256) through (312) Disability Income. Disability Income Premiums are to be separately entered depending upon category (Individual and Group). For Individual Disability Income, a further split is between noncancellable (NC) or other (guaranteed renewable, etc.). For Group Disability Income, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. In determining the premiums subject to the higher factors, Individual Disability Income NC and Other are combined. All types of Group and Credit Disability Income are combined in a different category from Individual.

STOP-LOSS ELECTRONIC-ONLY TABLES

The Health Risk-Based Capital (E) Working Group revised the stop-loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop-loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop-Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2019, will reflect the incurred data for calendar year 2018 run-out through December 31, 2019.

For those insurers where the stop-loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss (including aggregating specific) = This coverage was included in the 1998 to 2008 factor development.
Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.
HMO Reinsurance = Specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
Provider Excess = Specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
Medical Excess Reinsurance = Specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Do not include quota share or excess reinsurance written on stop-loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed, e.g., the RBC report filed for 2019 should provide experience information for calendar year 2018 with run-out through December 31, 2019. If the contract year does not follow a calendar year (e.g. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Contract 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims – These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.

+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio – This is equal to (Total Gross Claims + Expenses)/Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims – These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Electronic Table 2a – Calendar Year Specific Stop-Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop-Loss Contracts by Group Size

For those insurers where the stop-loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop-loss data and Table 2b should reflect the aggregate stop-loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (e.g. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop-loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) – The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point ($) (Table 2a, 50-99 Covered Lives in Group) =
(Sum of Specific Attachment Points X Reported Lives)/(Sum of Reported Lives)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Number of Lives	Include Exclude	Reason to Exclude
1	$200,000	115%	90	Include	
2	$100,000	120%	60	Include	
3	$50,000	140%	40	Exclude	Not in Group Size Band
4	$120,000	N/A	50	Include	
Calculation:	(200,000 x 90 + 100,000 x 60 + 120,000 x 50)/(90 + 60 + 50) = $150,000				

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop-loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =
(Sum of Expected Claims x Attachment Percentage %)/(Sum of Expected Claims)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Expected Claims	Number of Lives	Include Exclude	Reason to Exclude
1	$200,000	115%	$ 500,000	90	Include	
2	$100,000	120%	$ 300,000	60	Include	
3	$50,000	140%	$ 200,000	40	Exclude	Not in Group Size Band
4	$120,000	N/A	$ 400,000	50	Exclude	Aggregate not purchased by group
Calculation:	(500,000 x 115% + 300,000 x 120%)/(500,000 + 300,000) = 116.7%					

Footnote – The number of covered lives for stop-loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 13, Section C. Other Business, Line 2.

If stop-loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

Lines (323) through (401) Long Term Care. Long-Term Care Insurance (LTCI) Premiums are used to determine both a rate risk and the morbidity risk. The rate risk relates to all Noncancellable LTCI premiums. The morbidity risk is partially applied directly to premium with a higher factor (10%) applied to amounts up to $50,000,000 and a lower factor (3%) applied to premiums in excess of $50,000,000. In addition, the earned premiums and incurred claims for the last two years are used to determine an average loss ratio (incurred claims divided by earned premiums). This average loss ratio times the current year's premium is called Adjusted LTCI Claims for RBC. A higher factor (25%) is applied to claims up to $35,000,000 and a lower factor (8%) is applied to claims above $35,000,000. In certain situations where loss ratios cannot

be used because one of the values is zero or negative, the current year's incurred claims are used. In a situation where the current year's premium is not positive, higher factors are applied to current year's incurred claims to reflect the lack of a premium-based RBC. The RBC for LTCI is the sum of these three calculations.

Line (412) Limited Benefit Plans. There is a factor for certain types of Limited Benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5%) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (423) Accidental Death and Dismemberment. There is a factor for Accidental Death and Dismemberment (AD&D) insurance (where a single lump sum is paid) which depends on several items:

1. Three times the maximum amount of retained risk for any single claim;
2. $300,000 if 3 times the maximum amount of retained risk is larger than $300,000;
3. 5.5% of earned premium to the extent the premium for AD&D is less than or equal to $10,000,000; and
4. 1.5% of earned premium in excess of $10,000,000.

There are places for reporting the total amount of earned premium and maximum retained risk on any single claim. The actual RBC amount will be calculated automatically as the lesser of 1 and 2. That result is then added to 3 and 4.

Line (434) Other Accident. There is a factor for Other Accident coverage that provides for any accident-based contingency other than those contained in Line 43. For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

Line (445) Premium Stabilization Reserves. Premium stabilization reserves are funds held by the company in order to stabilize the premium a group policyholder must pay from year to year. Usually experience-rating refunds are accumulated in such a reserve so that they can be drawn upon in the event of poor future experience. This reduces the insurer's risk.

For health insurance, 50% of the premium stabilization reserves held in the annual statement as a liability (not as appropriated surplus) are permitted as an offset up to the amount of risk-based capital. The 50% factor was chosen to approximate the portion of premium stabilization reserves that would be an appropriate offset if the formula were applied on a contract-by-contract basis, and the reserve offset were limited to the amount of risk-based capital required for each contract.

Companies must list each group having 5% or more of the total premium stabilization reserve of the reporting entity. All other groups may be summarized on one line and labeled as various.

No credit is given here for premium stabilization reserves held for FEHBP and TRICARE coverage, because that coverage is already subject to a lesser percentage of premium in the underwriting risk calculation to reflect its reduced level of risk. Similarly, no credit is given here for any amounts held in connection with stand-alone Medicare Part D Coverage (i.e., amounts held as liabilities to the federal government under the risk-corridor mechanism), since Medicare Part D Coverage premium is already subject to a lesser factor in the underwriting risk calculation to reflect the reduced net level of risk. Amounts held as prepayments from the federal government for reinsurance coverage or low-income subsidy (cost-sharing portion) under Medicare Part D Coverage are not considered premium stabilization reserves as they relate to an uninsured plan.

As such, the company must exclude all amounts relating to FEHBP, TRICARE or stand-alone Medicare Part D Coverage in determining the amount of reserves to be reported.

HEALTH PREMIUMS and HEALTH CLAIMS RESERVES

LR019, LR023 and LR024

Basis of Factors

Risk-based capital factors for health insurance are applied to medical and disability income, long-term care insurance and other types of health insurance premiums and Exhibit 6 claim reserves with an offset for premium stabilization reserves. For health coverage that does not fit into one of the defined categories for risk-based capital, the "Other Health" category is to be used.

Medical Insurance Premium

The business is subdivided by product into categories for individual coverages and for group and credit coverages depending on the risk related to volatility of claims. The factors were developed from a model that determines the minimum amount of surplus needed to protect the company against a worst-case scenario for each type of coverage. The results of the model were then translated into either a uniform percentage or a two-tier formula to be applied to premium. The two-tier formula reflects the decreased risk of a larger in-force block. The formula includes several changes starting in 1998 for some types of health insurance. These changes add several worksheets and are designed to keep the RBC amounts for health coverage consistent regardless of the RBC formula used. If the company has comprehensive medical business **(Individual & Group)**, **Title XVIII Medicare, Title XIX Medicaid,** Medicare Supplement, **Vision, Dental** business, or Stand-Alone Medicare Part D coverage through a PDP arrangement, it will be directed to these additional worksheets. The instructions for including paid health claims in the various categories of the Managed Care Discount Factor Calculation can be found in the instructions to LR022 Underwriting Risk – Managed Care Credit. Appendix 32 of these instructions lists commonly used health insurance terms. Appendix 43 of these instructions ~~lists~~list commonly used terms specific to Stand-Alone Medicare Part D coverage. If the company has any of the ~~four~~ mentioned types of medical insurance, it will also be required to complete additional parts of the formula for C-3 Health Credit Risk and C-4 Health Administrative Expenses Risk portion of the Business Risk.

Disability Income Premium

Prior to 2001, the individual disability income factors were based on models of the disability risk completed by several companies with significant experience in this line. The group long-term disability income risk was modeled based on methodology similar to that used by one of the largest writers of this business. The pricing risk was addressed principally as the delayed reaction to increases in incidence of new claims and to the lengthening of claims from slower recoveries than assumed.

Starting in 2001, new categories and new factors are applicable to all types of disability income premiums. These factors are based on new data and apply a model similar to that used for other health premium risk to that data.

Long-Term Care Insurance Premium

Prior to 2005, factors equal to the original disability income factors were used. Starting in 2005, factors based on LTC experience replaced those factors. The difference in the factors used in 2004 and prior years for noncancellable LTC versus other LTC has been retained as a rate risk factor applied to the NC premium. The morbidity risk is partially applied directly to premium with a higher factor applied to amounts up to $50,000,000 and a lower factor applied to premiums in excess of $50,000,000. In addition, the earned premiums and incurred claims for the last two years are used to determine an average loss ratio (incurred claims divided by earned premiums). This average loss ratio times the current year's premium is called Adjusted LTC Claims for RBC. A higher factor is applied to claims up to $35,000,000 and a lower factor is applied to claims above $35,000,000.

Claim Reserves

Additional risk-based capital of 5% of claim reserves for both individual and group and credit is required to recognize the risk of the level of recoveries and other claim terminations falling below that assumed in the development of claim reserves. However, claims reserves for workers' compensation carve-out are excluded from this charge and are separately assessed risk-based capital on page LR021 Underwriting Risk – Other, Line (5); reserves entered for this exclusion should be reported in net balance sheet reserves in Schedule P, Part 1 of the Workers Compensation Carve-Out Supplement.

Pre-Tax and Post-Tax Factors

The formula uses pre-tax factors for all types of health insurance. Because many insurers of some types of health insurance write very little other business, it was determined that there would be no difference between pre-tax and post-tax factors except where substantial investment income is assumed as part of the product pricing. Thus, for disability income, the pre-tax factors in the table below and in LR023 Long-Term Care will be adjusted to post-tax by applying a tax-effect change to RBC in LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital. For reasons of practicality and simplicity, credit disability is included with other disability income and adjusted to post-tax. The pre-tax RBC values for other types of health insurance will not be adjusted.

Specific Instructions for Application of the Formula

The total of all earned premium categories LR019 Health Premiums, Line (~~31~~41), (Column (1) should equal Health Supplement Analysis of Operations Part 1 Columns 2 through 13 Line 1 + 2) ~~Column (1) should equal the total in Schedule H, Part 1, Line 2, Column 1~~ of the annual statement. Earned premium for each of these coverages should be from underlying company records. Earned premium may be reported in Health Supplement Analysis of Operations ~~Schedule H~~ for Administrative Services Contracts (ASC) and/or the Federal Employees Health Benefits Plan (FEHBP) and/or Workers Compensation Carve-Out, which are included in order that Line (~~31~~41) will equal the total in ~~Schedule H~~Health Supplement Analysis of Operations. As such, there is no RBC factor applied to any premium reported on Lines (~~18~~**26**), (~~28~~**36**), (38) or (~~29~~39). For some of the coverages, two-tier formulas apply. The calculations for these coverages shown below will not appear on the RBC filing software but will automatically be calculated by the software.

Lines 13, ~~16,17, 18, -19~~, 23-26, 29-33, 39, 42 and ~~3~~43 are not applicable to Fraternal Benefit Societies.

Line (1)

Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (1), Line (1.1).

Line (2)

Health premiums for Title XVIII Medicare written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (3), Line (1.1).

Line (3)

Health premiums for Title XIX Medicaid written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (4), Line (1.1).

Line (~~4~~2)

Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (5~~2~~), Line (1.1).

Line (5~~3~~)

Health premiums for ~~dental or~~ vision only coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (6~~3~~), Line (1.1).

Line (5~~6~~)

Health premiums for dental only coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (7), Line (1.1).

Line (74)
Health premium for Stand-Alone Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 43 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (31). No RBC requirement is calculated in Column (2). The premium is carried forward to page LR020 Underwriting Risk – Experience Fluctuation Risk Column (84) Line (1.1).

Line (85)
Health incurred claims for Supplemental benefits within Stand-Alone Medicare Part D coverage written on individual contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible. This does not include the low-income subsidy (cost sharing portion), which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Stand-Alone Medicare Part D Coverage on LR019.

Line (96) and (2216)
Medicaid pass-through payments reported as premium and excluded from Line (1) should be reported in Line (6) or (16).

Line (107) and Line (2317)
There is a factor for certain types of limited benefit coverage (hospital indemnity, which includes a per diem for intensive care facility stays, and specified disease) which includes both a percent of earned premium on such insurance (3.5%) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (118) and Line (2418)
The factor for accidental death and dismemberment (AD&D) insurance (where a single lump sum is paid) depends on several items:

1. Three times the maximum amount of retained risk for any single claim;
2. $300,000 if three times the maximum amount of retained risk is larger than $300,000;
3. 5.5% of earned premium to the extent the premium for AD&D is less than or equal to $10,000,000; and
4. 1.5% of earned premium in excess of $10,000,000.

There are places for reporting the total amount of earned premium and the maximum retained risk on any single claim. The actual RBC Requirement will be calculated automatically as the sum of (a) the lesser of items 1 and 2 plus (b) items 3 plus 4.

Line (129) and Line (2519)
The factor for Other Accident coverage provides for any accident-based contingency other than those contained in Lines (811) or (1824). For example, this line should contain all the premium for policies that provide coverage for accident-only disability or accident-only hospital indemnity. The premium for policies that contain AD&D in addition to other accident-only benefits should also be shown on this line.

Line (130)
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (21), Line (1.2).

Line (14)
Health premiums for Title XVIII Medicare written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (3), Line (1.2).

Line (15)
Health premiums for Title XIX Medicaid written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (4), Line (1.2).

Line (161)
Health premiums for ~~dental or~~ vision only coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (63), Line (1.2).

Line (17)
Health premiums for dental only coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (7), Line (1.2).

Line (182)
The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Line (3240)). It is not expected that the transfer of risk through the

various managed care credits will reduce the risk of stop-loss coverage. Medical Stop Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35% will be applied to the first $25,000,000 in premium and a factor of 25% will be applied to the premium in excess of $25,000,000. Stop loss premiums should be reported on a net basis.

Line (193)
Health premiums for Medicare supplement written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (52), Line (1.2).

Line (2014)
Health premium for Stand-Alone Medicare Part D coverage written on group contracts only if the plan sponsor has risk corridor protection for the contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor protection payments. See Appendix 3 4 for definition of these terms. Stand-Alone Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (340) Other Health. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (1429). No RBC requirement is calculated in Column (2). The premium is carried forward to page LR020 Underwriting Risk – Experience Fluctuation Risk Column (84) Line (1.2).

Line (22115)
Health incurred claims for Supplemental benefits within Stand-Alone Medicare Part D coverage written on group contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible where the plan sponsor has risk corridor protection for the group contract's standard benefit design coverage. This does not include the low-income subsidy (cost-sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Part D Coverage on LR019.

Lines (21627) through (22733)
Disability income premiums are to be separately entered depending upon category (individual and group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.) For group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of group and credit are combined in a different category from individual.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 19) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b) etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

	Disability Income Premium	Annual Statement Source	(1) Statement Value	Factor	(2) RBC Requirement
Line (271)	Noncancellable Disability Income - Individual Morbidity	Earned Premium included in ~~Schedule H, Part 1, Line 2,~~ Health Supplement Analysis of Operations 11, Line 1 + 2, in part			
a)	First $50 Million Earned Premium of Line (271)	Company Records		X 0.4435 =	
b)	Over $50 Million Earned Premium of Line (271)	Company Records		X 0.1901 =	
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (271) + b) of Line (271), Column (2)			

Line (282)	Other Disability Income - Individual Morbidity	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (282) [up to $50 million less premium in a) of Line (27~~1~~)]	Company Records		X 0.3168 =	
b)	Earned Premium in Line (282) not included in a) of Line (282)	Company Records		X 0.0889 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (282) + b) of Line (282), Column (2)			
Line (293)	Disability Income - Credit Monthly Balance	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	First $50 Million Earned Premium of Line (293)	Company Records		X 0.2534 =	
b)	Over $50 Million Earned Premium of Line (293)	Company Records		X 0.0378 =	
c)	Total Disability Income - Credit Monthly Balance	a) of Line (293) + b) of Line (293), Column (2)			
Line (3024)	Disability Income – Group Long-Term	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (3024) [up to $50 million less premium in a) of Line (293)]	Company Records		X 0.1901 =	
b)	Earned Premium in Line (3024) not included in a) of Line (3024)	Company Records		X 0.0378 =	
c)	Total Disability Income – Group Long-Term	a) of Line (3024) + b) of Line (3024), Column (2)			
Line (3125)	Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part. This amount to be reported on LR019 Health Premiums, Line (3125)			
a)	Additional Reserves for Credit Disability Plans	LR019 Health Premiums Column (1) Line (4234)			
b)	Additional Reserves for Credit Disability Plans, Prior Year	LR019 Health Premiums Column (1) Line (4335)			
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (3125) - a) of Line (3125) + b) of Line (3125)			
d)	Earned Premium in c) [up to $50 million less premium in a) of Line (293) + a) of Line (3024)]	Company Records		X 0.1901 =	
e)	Earned Premium in c) of Line (3125) not included in d) of Line (3125)	Company Records		X 0.0378 =	
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (3125) + e) of Line (3125), Column (2)			

Line (3226)	Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (3226) [up to $50 million less premium in a) of Line (293) + a) of Line (3024) + d) of Line (3125)]	Company Records		X 0.1267 =	
b)	Earned Premium in Line (3226) not included in a) of Line (3226)	Company Records		X 0.0378 =	
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (3226) + b) of Line (3226), Column (2)			

Line (3327)	Disability Income – Group Short-Term	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (3327) [up to $50 million less premium in a) of Line (293) + a) of Line (3024) + d) of Line (3125) + a) of Line (3226)]	Company Records		X 0.0634 =	
b)	Earned Premium in Line (3327) not included in a) of Line (3327)	Company Records		X 0.0378 =	
c)	Total Disability Income – Group Short-Term	a) of Line (3327) + b) of Line (3327), Column (2)			

Lines (3528) and (3629)

Premiums for noncancellable long-term care insurance are included on Line (3528) to reflect the additional risk when rate increases are not permitted. Line (3629) includes premiums for Other LTC coverage but with no RBC value on this page (the RBC is determined on LR023 Long-Term Care) so that the validation check to ~~Schedule H~~Health Supplement Analysis of Operations can still be performed.

Line (391)

Premiums for Workers' Compensation Carve-Out are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The RBC Requirement assessed on these premiums can be found on page LR021 Underwriting Risk – Other, Line (4).

Line (4032)

It is anticipated that most health premium will have been included in one of the other lines. In the event that some coverage does not fit into any of these categories, the "Other Health" category continues the RBC factor from the 1998 and prior formula for Other Limited Benefits Anticipating Rate Increases. Stop loss premiums are addressed separately in Line (182).

Stop Loss Electronic Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2018, will reflect the incurred data for calendar year 2017 run-out through December 31st, 2018.

For those insurers where the stop loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.
Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.
HMO Reinsurance = specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
Medical Excess Reinsurance = specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for 2018 should provide experience information for calendar year 2017 with run-out through December 31st, 2018. If the contract year does not follow a calendar year (i.e. 7/1- 6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability. .

+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to I(Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2**a** – Calendar Year Specific Stop Loss Contracts By Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contracts by Group Size

For those insurers where the stop loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (i.e. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop loss contract based on the number of covered lives in the group.

Average Specific Attachment Point **(**Table 2a**)** - The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point ($) (Table 2a, 50-99 Covered Lives in Group) =

(Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Number of Lives	Include Exclude	Reason to Exclude
1	$ 200,000	115%	90	Include	
2	$ 100,000	120%	60	Include	
3	$ 50,000	140%	40	Exclude	Not in Group Size Band
4	$ 120,000	N/A	50	Include	

Calculation: (200,000 x 90 + 100,000 x 60 + 120,000 x 50) / (90 + 60 + 50) = $150,000

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the count of covered lives within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =
(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Expected Claims	Number of Lives	Include Exclude	Reason to Exclude
1	$ 200,000	115%	$ 500,000	90	Include	
2	$ 100,000	120%	$ 300,000	60	Include	
3	$ 50,000	140%	$ 200,000	40	Exclude	Not in Group Size Band
4	$ 120,000	N/A	$ 400,000	50	Exclude	Aggregate not purchased by group

Calculation: (500,000 x 115% + 300,000 x 120%) / (500,000 + 300,000) = 116.7%

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 6, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

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 $500,000 per line for medical coverage, $50,000 total for all other coverage except Medicare Part D coverage, and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (i.e., writing more than one coverage type), the total alternate risk charge is the highest of the cumulative alternate risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Dental only, Vision Only); Medicare Part D; and Other Health. For example, if an organization writes Comprehensive – Individual, Comprehensive – Group, Vision Only, and Dental Only, the alternate risk charge is $1,000,000 (the cumulative charge for Comprehensive – Individual and Comprehensive – Group, which is higher than the $100,000 cumulative charge for Vision Only and Dental Only.)~~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 (19~~8~~)

There are eight~~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~~ eight lines of business are: Column (1) Comprehensive Medical and Hospital - Individual; Column (2) Comprehensive Medical and Hospital - Group; Column (3) Title XVIII Medicare; Column (4) Title XIX Medicaid; Column (5~~2~~) Medicare Supplement; Column (6~~3~~) ~~Dental &~~ Vision Only; Column (7) Dental Only; and Column (8~~4~~) Stand-Alone Medicare Part D coverage. Each of the ~~four~~ eight 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.

For details of each category refer to LR019 instructions.

~~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~~ 4 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 (~~2~~42) 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 (3) Medicaid Pass-Through Payments Reported as Premiums
Medicaid Pass-Through Payments that are included as premiums. Equals the total of LR019 Lines (9) and (22)

Line (~~4~~5) Underwriting Risk Revenue
~~The sum of~~ Lines (1.3) ~~through~~ + (24) – (3).

Line (~~5~~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~~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. Line (56) does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

~~Column (1) claims come from Schedule H, Part 5, Columns 1 and 2 Line 13 less the amounts reported as incurred claims for administrative services contracts (ASC) in Line (54) of LR029 Business Risk and Federal Employee Health Benefit Program (FEHBP) in Line (3) of LR021 Underwriting Risk – Other. 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 5, Line 13.~~

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix ~~3~~4). 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 (6) Medicaid Pass-Through Payments Reported as Claims.

Medicaid Pass-Through Payments that are included as claims.

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
Lines (56) ~~– minus Line~~ (~~67~~) – (7).

Line (9) Underwriting Risk Claims Ratio
Line (8) / Line (~~45~~). If either Line (~~45~~) or Line (8) is zero or negative, Line (9) is zero.

Line (10) ~~Underwriting Risk Factor~~Underwriting Risk Factors for Initial Amounts of Premium
Factor applied to the first $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to the first $3,000,000 in premium for columns (5), (6), (7),
~~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~~	~~0.14341440~~	~~0.14341440~~	~~0.08380844~~
~~Medicare Supplement~~	~~0.09800987~~	~~0.06030609~~	~~0.06030609~~
~~Dental~~	~~0.11481153~~	~~0.07110716~~	~~0.07110716~~
~~Stand-Alone Medicare Part D Coverage~~	~~0.251~~	~~0.251~~	~~0.151~~

Line (11) Underwriting Risk Factors for Excess of Initial Amount
Factor applied to premium in excess of $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to premium in excess of $3,000,000 in premium for columns (5), (6), (7),

Line (12) Investment Income Adjustment Factor
The investment income yield was incorporated into the Comprehensive (Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 4.5% income yield that was based on the yield of a 6-month U.S. Treasury bond. Each year, the Working Group will identify the yield of the 6-month U.S. Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modification to the 4.5% adjustment is needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (13) Composite Underwriting Risk Factor.
A weighted average factor based on the amount reported in Line (4), Underwriting Risk Revenue. Includes the Investment Income Adjustment Factor.

Line (1~~4~~1) Base Underwriting Risk RBC
Line (~~45~~) x Line (9) x Line (1~~3~~0.~~3~~).

Line (1~~5~~2) Managed Care Discount Factor
For Comprehensive Medical & Hospital Individual, Comprehensive Medical & Hospital Group, Title XVIII Medicare, Title XIX Medicaid, Medicare Supplement (including Medicare Select), Vision, 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 (16~~3~~) Base RBC After Managed Care Discount
Line (14~~1~~) x Line (15~~2~~).

~~Line (14) RBC Adjustment for Individual~~
~~The average experience fluctuation risk charge is increased by 20% 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)~~
~~+$67,500 (10% of $675,000 coverage layer)~~
~~=$142,500~~

Line (17~~6~~) 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~~. $500,000 for Columns (1), (2), (3), and (4); $50,000 for Columns (5), (6), and (7); and $150,000 for Column (8).

Line (18~~7~~) Net Alternate Risk Charge
~~The largest value from Line (16) is retained for that column in Line (17) and all others are ignored.~~ The alternate risk charge is $500,000 per line for medical coverage, $50,000 total for all other coverage except Medicare Part D coverage, and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (i.e., writing more than one coverage type), the total alternate risk charge is the highest of the cumulative alternate risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Dental only, Vision Only); Medicare Part D; and Other Health.

Line (19~~8~~) Net Underwriting Risk RBC
The maximum of Line (16~~4~~) and Line (18~~7~~).

LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS
PR019 – PR026

If the reporting company writes 5% or more of its premiums in A&H lines in 2024~~3~~, 2025~~4~~ or 2026~~5~~, this section of the formula must be completed. To determine if that applies, take the sum of Lines 13, 14 and 15 of the Underwriting and Investment Exhibit Part 1B Column 6 and divide by Line 35 Column 6, and round to three decimals for each individual year. If the result is at least 0.050 in any year, this exhibit and the appropriate Schedule P adjustment must be completed.

If the company writes less than 5% of its premiums in A&H lines in 2024~~3~~, 2025~~4~~ and 2026~~5~~, disregard this section.

PR019 - Health Premiums

Basis of Factors

Risk-based capital factors for health insurance are applied to medical, disability income, long-term care insurance and other types of health insurance premiums and claim reserves with an offset for premium stabilization reserves. For health coverage that does not fit into one of the defined categories for risk-based capital, the "Other Health" category is to be used.

Medical Insurance Premium

The business is subdivided by product into categories for individual coverages and for group and credit coverages depending on the risk related to volatility of claims. The factors were developed from a model that determines the minimum amount of surplus needed to protect the company against a worst-case scenario for each type of coverage. The results of the model were then translated into either a uniform percentage or a two-tier formula to be applied to premium. The two-tier formula reflects the decreased risk of a larger in-force block. The formula includes several changes starting in 1999 for some types of health insurance. These changes add several additional worksheets and are designed to keep the RBC amounts for health coverage consistent regardless of the RBC formula used. If the company has Comprehensive Medical business, Medicare Supplement, Dental & Vision business, or Stand-Alone Medicare Part D coverage through a PDP arrangement, it will be directed to these additional worksheets. The instructions for including paid health claims in the various categories of the Managed Care Discount Factor Calculation can be found in the instructions to PR021 Underwriting Risk – Managed Care Credit. Appendix 1 - Commonly Used Health Insurance Terms have~~s~~ been added to these instructions. Appendix 2 of these instructions lists commonly used terms of Stand-Alone Medicare Part D coverage. If the company has any of the three mentioned types of medical insurance, it will also be required to complete additional parts of the formula for Health Credit Risk (PR013) and Health Administrative Expenses portion in PR022.

Disability Income Premium

Prior to 2001, the individual disability income factors were based on models of the disability risk completed by several companies with significant experience in this line. The group long-term disability income risk was modeled based on methodology similar to that used by one of the largest writers of this business. The pricing risk was addressed principally as the delayed reaction to increases in incidence of new claims and to the lengthening of claims from slower recoveries than assumed.

Starting in 2001, new categories and new factors are applicable to all types of disability income premiums. These factors are based on new data and apply a model similar to that used for other health premium risk to that data.

All premium should be reported on a net of reinsurance basis.

Specific Instructions for Application of the Formula

The total of all earned premium categories PR019 Health Premiums, Line (36~~26~~), Column (1) should equal the total in ~~Schedule H~~ Underwriting and Investment Exhibit, Part 1, Line 13.1 through 15.9~~2~~, Column 4~~1~~ of the Annual Statement. Earned premium for each of these coverages should be from underlying company records. Earned premium may be reported in ~~Schedule H~~Underwriting and Investment Exhibit for Administrative Services Contract (ASC) and/or the Federal Employees Health Benefit Program (FEHBP) which are included in order that Line (36~~26~~) will equal the total in ~~Schedule H~~Underwriting and Investment Exhibit. As such, there is no RBC factor applied to any premium reported on lines (22~~14~~), (32~~23~~)

or (3424). For some of the coverages, two tier formulas apply. The calculations for these coverages shown below will not appear on the RBC filing software but will automatically be calculated by the software.

Line (1)
Health premiums for comprehensive (medical and hospital), which includes expense reimbursement hospital/medical coverage) written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (1) Line (1.1). ~~Medicaid Pass-Through Payments reported as premium in the annual statement filing should be excluded from the premium amounts reported in Line 1 and reported in Line (3.3) and (10.3), respectively.~~

Line (2)
Health premiums for Title XVIII Medicare written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.1).

Line (3)
Health premiums for Title XIX Medicaid written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.1).

Line (42)
Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (52) Line (1.1).

Line (53)
Health premiums for ~~dental or~~ vision only coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (63) Line (1.1).

Line (6)
Health premiums for dental only coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (7) Line (1.1).

Line (73.1)
Health premium for Stand-Alone Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (21). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (84) Line (1.1).

Line (73.2)
Health incurred claims for Supplemental benefits within Stand-Alone Medicare Part D coverage written on individual contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible. This does not include the low-income subsidy (cost sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Stand-Alone Medicare Part D Coverage on PR019.

Line (73.3)
Medicaid pass-through payments reported as premium ~~and excluded from Line (1) should be reported in Line (3.3)~~.

Line (84) and Line (191)
There is a factor for certain types of limited benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5%) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (95) and Line (2012)
There is a factor for accidental death and dismemberment (AD&D) insurance (where a single lump sum is paid) which depends on several items:

1. The maximum amount of retained risk for any single claim;
2. $300,000 if three times the maximum amount of retained risk is larger than $300,000;
3. 5.5% of earned premium to the extent the premium for AD&D is less than or equal to $10,000,000; and
4. 1.5% of earned premium in excess of $10,000,000.

There are places for reporting the total amount of earned premium and the maximum retained risk on any single claim. The actual RBC amount will be calculated automatically as the sum of (a) the lesser of items 1 and 2; plus (b) items 3 plus 4.

Line (106) and Line (2113)
A 5% factor for Other Accident coverage provides for any accident based contingency other than those contained in Lines (95) or (2012). For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

Line (117)
Health premiums for comprehensive (medical and hospital), which includes expense reimbursement hospital/medical coverage) written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (21) Line (1.2).

Line (12)
Health premiums for Title XVIII Medicare written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.2).

Line (13)
Health premiums for Title XIX Medicaid written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.2).

Line (148)
Health premiums for ~~dental or~~ vision only coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (63) Line (1.2).

Line (15)
Health premiums for dental only coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (7) Line (1.2).

Line (169)
The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Line (325)). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35% will be applied to the first $25,000,000 in premium and a factor of 25% will be applied to the premium in excess of $25,000,000. Stop-loss premiums should be reported on a net basis.

Line (170)
Health premiums for Medicare supplement written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (52) Line (1.2).

Line (180.1)
Health premium for Stand-Alone Medicare Part D coverage written on group contracts only if the plan sponsor has risk corridor protection for the contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor protection payments. See Appendix 2 for definition of these terms. Stand-Alone Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (325) Other Health. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (169). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (84) Line (1.2).

Line (180.2)
Health Incurred Claims for Supplemental benefits within Stand-Alone Medicare Part D coverage written on group contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible where the plan sponsor has risk corridor protection for the group contract's standard benefit design coverage. This does not include the low-income subsidy (cost-sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Part D Coverage on PR019.

Line (180.3)
Medicaid pass-through payments reported as premium ~~and excluded from Line (7) should be reported in Line (10.3)~~.

Lines (2315) through (3424)

Disability income premiums are to be separately entered depending on category (Individual and Group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.) For Group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). For long-term care insurance, premiums are reported separately for Individual noncancellable, Individual (other than NC) and Group LTCI. The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of Group and Credit are combined in a different category from Individual. For long-term care, all types (Individual and Group) are combined.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 2315) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b), etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

		Annual Statement Source	Statement Value	Factor	RBC Requirement
	Disability Income Premium				
Line (2315)	Noncancellable Disability Income - Individual Morbidity	Earned Premium included in U&I Part 1, Column 4 Line 15.3 ~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	First $50 Million Earned Premium of Line (2315)	Company Records		X 0.350 =	
b)	Over $50 Million Earned Premium of Line (2315)	Company Records		X 0.150 =	
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (2315) + b) of Line (2315), Column (2)			
Line (2416)	Other Disability Income – Individual Morbidity	Earned Premium included in U&I Part 1, Column 4 Line 15.3 ~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	Earned Premium in Line (2416) [up to $50 million less premium in a) of Line (2315)]	Company Records		X 0.250 =	
b)	Earned Premium in Line (2416) not included in a) of Line (2416)	Company Records		X 0.070 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (2416) + b) of Line (2416), Column (2)			
Line (2517)	Disability Income - Credit Monthly Balance	Earned Premium included in U&I Part 1, Column 4 Line 15.3 ~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	First $50 Million Earned Premium of Line (2517)	Company Records		X 0.200 =	
b)	Over $50 Million Earned Premium of Line (2517)	Company Records		X 0.030 =	
c)	Total Disability Income - Credit Monthly Balance	a) of Line (2517) + b) of Line (2517), Column (2)			
Line (2618)	Disability Income – Group Long Term	Earned Premium included in U&I Part 1, Column 4 Line 15.3 ~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	Earned Premium in Line (2618) [up to $50 million less premium in a) of Line (2517)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (2618) not included in a) of Line (2618)	Company Records		X 0.030 =	
c)	Total Disability Income – Group Long Term	a) of Line (2618) + b) of Line (2618), Column (2)			

		Annual Statement Source	Statement Value	Factor	RBC Requirement
	Disability Income Premium				
Line (27~~19~~)	Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in U&I Part 1, Column 4 Line 15.3~~Schedule H, Part 1, Column 21, Line 2,~~ in part. This amount to be reported on Health Premiums, Line (27~~19~~)			
a)	Additional Reserves for Credit Disability Plans	PR019 Health Premiums Column (1) Line (37~~27~~)			
b)	Additional Reserves for Credit Disability Plans, Prior Year	PR019 Health Premiums Column (1) Line (38~~28~~)			
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (27~~19~~) - a) of Line (27~~19~~) + b) of Line (27~~19~~)			
d)	Earned Premium in c) [up to $50 million less premium in a) of Line (25~~17~~) + a) of Line (26~~18~~)]	Company Records		X 0.100 =	
e)	Earned Premium in c) of Line (27~~19~~) not included in d) of Line (27~~19~~)	Company Records		X 0.030 =	
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (27~~19~~) + e) of Line (27~~19~~), Column (2)			
Line (2~~8~~0)	Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in U&I Part 1, Column 4 Line 15.3~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	Earned Premium in Line (2~~8~~0) [up to $50 million less premium in a) of Line (25~~17~~) + a) of Line (26~~18~~) + d) of Line (27~~19~~)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (2~~8~~0) not included in a) of Line (2~~8~~0)	Company Records		X 0.030 =	
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (2~~8~~0) + b) of Line (2~~8~~0), Column (2)			
Line (2~~9~~1)	Disability Income – Group Short Term	Earned Premium included in U&I Part 1, Column 4 Line 15.3~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	Earned Premium in Line (2~~9~~1) [up to $50 million less premium in a) of Line (25~~17~~) + a) of Line (26~~18~~) + d) of Line (27~~19~~) + a) of Line (2~~8~~0)]	Company Records		X 0.050 =	
b)	Earned Premium in Line (2~~9~~1) not included in a) of Line (2~~9~~1)	Company Records		X 0.030 =	
c)	Total Disability Income – Group Short Term	a) of Line (2~~9~~1) + b) of Line (2~~9~~1), Column (2)			
Line (31~~22~~)	Noncancellable Long-Term Care Premium – Rate risk	Earned Premium (U&I Part 1, Column 4 Line 15.7~~Schedule H, Part 1, Column 23, Line 2~~, in part)		X 0.100 =	

Line (~~2~~35)

Most Health Premium will have been included in one of the prior lines. In the event that some coverage does not fit into any of these categories, "Other Health" category is applied with a 12% factor, which is from 1998 formula for Other Limited Benefits Anticipating Rate Increases. Stop-loss premiums are addressed separately in Line (16~~9~~).

Stop-Loss Electronic-Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop-loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop-loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop-Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end **2018**, will reflect the incurred data for calendar year **2017** run-out through December 31, **2018**.

For those insurers where the stop-loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop-Loss (including aggregating specific) = This coverage was included in the 1998 to 2008 factor development.
Aggregate Stop-Loss = This coverage was included in the 1998 to 2008 factor development.
HMO Reinsurance = Specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
Provider Excess = Specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
Medical Excess Reinsurance = Specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on stop-loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for **2019** should provide experience information for calendar year **2018** with run-out through December 31, **2019**. If the contract year does not follow a calendar year (e.g., 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Contract 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.
Total Gross Claims + Expenses =

Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability. .

+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2a – Calendar Year Specific Stop-Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop-Loss Contract by Group Size

For those insurers where the stop-loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop-loss data and Table 2b should reflect the aggregate stop-loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (e.g. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop-loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) - The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point ($) (Table 2a, 50-99 Covered Lives in Group) =

(Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Number of Lives	Include Exclude	Reason to Exclude
1	$ 200,000	115%	90	Include	
2	$ 100,000	120%	60	Include	
3	$ 50,000	140%	40	Exclude	Not in Group Size Band
4	$ 120,000	N/A	50	Include	

Calculation: (200,000 x 90 + 100,000 x 60 + 120,000 x 50) / (90 + 60 + 50)

= $150,000

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop-loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =
(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

Insured Group	Specific Att Point ($)	Aggregate Att (%)	Expected Claims	Number of Lives	Include Exclude
1	$ 200,000	115%	$ 500,000	90	Include
2	$ 100,000	120%	$ 300,000	60	Include
3	$ 50,000	140%	$ 200,000	40	Exclude
4	$ 120,000	N/A	$ 400,000	50	Exclude

Calculation: (500,000 x 115% + 300,000 x 120%) / (500,000 + 300,000)
= 116.7%

Footnote – The number of covered lives for stop-loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 13, Section C. Other Business, Line 2.

If stop-loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

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.

The columns are as follows:

Column (1) – Comprehensive (Hospital & Medical) Individual Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes Short-Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.

Column (2) – Comprehensive (Hospital & Medical) Group Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes Short-Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.

Column (3) – Title XVIII Medicare Policies issued as Medicare Advantage Plans providing Medicare benefits to Medicare eligible beneficiaries created by title XVIII of the Social Security Act of 1965. This includes Medicare Managed Care Plans (i.e., HMO and PPO) and Medicare Private Fee-for-Service Plans. This also includes all Medicare Part D Prescription Drug Coverage through a Medicare Advantage product and whether sold directly to an individual or through a group.

Column (4) – Title XIX Medicaid Policies issued in association with the Federal/State entitlement program created by Title XIX of the Social Security Act of 1965 that pays for medical assistance for certain individuals and families with low incomes and resources.

Column (5) – Medicare Supplement. Policies that qualify as Medicare Supplement policy forms as defined in the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This includes standardized plans, pre-standardized plans and Medicare select. Does not include Medicare (Title XVIII) or Medicaid (Title XIX) risk contracts.

Column (6) – Vision Only Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. Does not include self-insured business, federal employees health benefit plans (FEHBP), or Medicare and Medicaid programs.

Column (7) – Dental Only Policies providing for dental only coverage (dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw) issued as stand-alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category. Does not include self-insured business, as well as federal employee's health benefits plans (FEHBP), or Medicare and Medicaid programs.

Column (8) – 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 PR019. 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

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 $500,000 per line for medical coverage, $50,000 total for all other coverage except Medicare Part D coverage, and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (i.e., writing more than one coverage type), the total alternate risk charge is the highest of the cumulative alternate risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Dental only, Vision Only); Medicare Part D; and Other Health. For example, if an organization writes Comprehensive – Individual, Comprehensive – Group, Vision Only, and Dental Only, the alternate risk charge is $1,000,000 (the cumulative charge for Comprehensive – Individual and Comprehensive – Group, which is higher than the $100,000 cumulative charge for Vision Only and Dental Only.)~~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 (19~~8~~)

There are ~~four~~ eight 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~~ eight lines of business are Column (1) Comprehensive Medical ~~and Hospital~~Individual; Column (2) Comprehensive Medical Group; Column (3) Title XVIII Medicare; Column (4) Title XIX Medicaid; Column (5~~2~~) Medicare Supplement; Column (6~~3~~) ~~Dental &~~ Vision; Column (7) Dental; and Column (8~~4~~) Stand-Alone Medicare Part D coverage. Each of the ~~four~~ eight 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.

The Line 1.3 sources for each column are given in the table below:

PR020 Column	**Annual Statement Source**
Comprehensive Medical Individual	U&I Part 1, Column 4 Line 13.1
Comprehensive Medical Group	U&I Part 1, Column 4 Line 13.2
Title XVIII Medicare	U&I Part 1, Column 4 Line 15.6
Title XIX Medicaid	U&I Part 1, Column 4 Line 15.5
Medicare Supplement	U&I Part 1, Column 4 Line 15.4
Vision	U&I Part 1, Column 4 Line 15.1
Dental	U&I Part 1, Column 4 Line 15.2
Stand-Alone Medicare Part D Coverage	Company Records, Earned Premium Net of Reinsurance

~~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 (24) 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 (3) Medicaid Pass-Through Payments Reported as Premiums.
Amount is equal to the total amount reported in PR019 Lines 7.3 and Line 18.3

Line (45) Underwriting Risk Revenue
~~The sum of~~ Line~~s~~ (1.3) ~~+~~ Lines (2) – Line (3) ~~through (4)~~.

Line (56) 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.

PR020 Column	**Annual Statement Source**
Comprehensive Medical Individual	U&I Part 2, Column 7 Line 13.1
Comprehensive Medical Group	U&I Part 2, Column 7 Line 13.2
Title XVIII Medicare	U&I Part 2, Column 7 Line 15.6
Title XIX Medicaid	U&I Part 2, Column 7 Line 15.5
Medicare Supplement	U&I Part 2, Column 7 Line 15.4
Vision	U&I Part 2, Column 7 Line 15.1
Dental	U&I Part 2, Column 7 Line 15.2
Stand-Alone Medicare Part D Coverage	Company Records

~~Column (1) claims come from Annual Statement, Schedule H, Part 5 Column 1+2+7+8 Line D1 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. Column (2) claims come from Schedule H, Part 5, Column 3, Line D1. Column (3) dental and vision claims come from Schedule H, Part 5, Columns 4+5, Line D11.)~~

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 (6) Medicaid Pass-Through Payments Reported as Claims.
Medicaid pass-through payments that were included as claims reported in Line (5)

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 (56) – Line (6) ~~minus~~ Line (7).

Line (9) Underwriting Risk Claims Ratio
Line (8) / Line (45). If either Line (45) or Line (8) is zero or negative, Line (9) is zero.

Line (10) Underwriting Risk Factor for Initial Amounts of Premium. Factor applied to the first $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to the first $3,000,000 in premium for columns (5), (6), (7),

Line (11) Underwriting Risk Factor for Excess of Initial Amount. Factor applied to premium in excess of $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to premium in excess of $3,000,000 in premium for columns (5), (6), (7),

Line (12) Investment Income Adjustment Factor
The investment income yield was incorporated into the Comprehensive (Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 4.5% income yield that was based on the yield of a 6-month U.S. Treasury bond. Each year, the Working Group will identify the yield of the 6-month U.S. Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modification to the 4.5% adjustment is needed. Any adjustments will be rounded up to the nearest 0.5%.

~~Line (10) Underwriting Risk Factor~~
~~A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue.~~

	~~$0 - $3 Million~~	~~$3 - $25 Million~~	~~Over $25 Million~~
~~Comprehensive Medical~~	~~0.1427~~0.1440	~~0.1427~~0.1440	~~0.0832~~0.0844
~~Medicare Supplement~~	~~0.0973~~0.0987	~~0.0596~~0.0609	~~0.0596~~0.0609
~~Dental & Vision~~	~~0.1143~~0.1153	~~0.0706~~0.0716	~~0.0706~~0.0716
~~Stand-Alone Medicare Part D Coverage~~	~~0.251~~	~~0.251~~	~~0.151~~

Line (13) Composite Underwriting Risk Factor
A weighted average factor based on the amount reported in Line (4), Underwriting Risk Revenue. Includes the Investment Income Adjustment Factor

Line (14~~1~~) Base Underwriting Risk RBC
Line (4~~5~~) x Line (9) x Line (13~~0.3~~).

Line (15~~2~~) Managed Care Discount
For Comprehensive Medical & Hospital Individual, Comprehensive Medical & Hospital Group, Title XVIII Medicare, Title XIX Medicaid, Medicare Supplement (including Medicare Select), Vision, 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 (16~~3~~) Base RBC After Managed Care Discount
Line (14~~1~~) x Line (15~~2~~).

~~Line (14) RBC Adjustment for Individual~~
~~The average Experience Fluctuation Risk charge is increased by 20% 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)~~
	~~+$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)~~
	~~+$67,500~~	~~(10% of $675,000 coverage layer)~~
	~~=$142,500~~	

Line (17~~6~~) Alternate Risk Charge

$500,000 for Columns (1), (2), (3), and (4); $50,000 for Columns (5), (6), and (7); and $150,000 for Column (8).~~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 (18~~7~~) Net Alternate Risk Charge

~~The largest value from Line (16) is retained for that column in line (17) and all others are ignored.~~ The alternate risk charge is $500,000 per line for medical coverage, $50,000 total for all other coverage except Medicare Part D coverage, and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (i.e., writing more than one coverage

type), the total alternate risk charge is the highest of the cumulative alternate risk charges for each of the following: Comprehensive (Comprehensive – Individual, Comprehensive – Group, Title XVIII – Medicare, Title XIX – Medicaid); Medicare Supplement; Dental & Vision (Dental only, Vision Only); Medicare Part D; and Other Health.

Line (198) Net Underwriting Risk RBC
The maximum of Line (164) and Line (187).

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UNDERWRITING RISK

Experience Fluctuation Risk

		Line of Business	(1) Comprehensive (Hospital & Medical) - Individual	(2) Comprehensive (Hospital & Medical) - Group	(3) Title XVIII - Medicare	(4) Title XIX - Medicaid	(5) Medicare Supplement	(6) Vision Only	(7) Dental Only	(8) Stand-Alone Medicare Part D Coverage	(9) Other Health	(10) Other Non-Health	(11) Total
(1)	†	Premium											
(2)	†	Other Health Risk Revenue					XXX					XXX	
(3)		Medicaid Pass-Through Payments Reported as Premiums	XXX	XXX	XXX		XXX	XXX	XXX	XXX	XXX	XXX	
(4)		Underwriting Risk Revenue (1) + (2) – (3)											
(5)	†	Net Incured Claims										XXX	
(6)		Medicaid Pass-Through Payments Reported as Claims	XXX	XXX	XXX		XXX	XXX	XXX	XXX	XXX	XXX	
(7)	†	Fee-For-Service Offset					XXX					XXX	
(8)		Underwring Risk Incurred Claims (5) – (6) – (7)										XXX	
(9)		Underwriting Risk Claim Ratio (8)/(4)										1.000	XXX
(10)		Underwriting Risk Factor for Initial Amounts of Premium‡	0.1440	0.1440	0.1440	0.1440	0.0987	0.1153	0.1153	0.251	0.130	0.130	XXX
(11)		Underwriting Risk Factor for Excess of Initial Amount‡	0.0844	0.0844	0.0844	0.0844	0.0609	0.0716	0.0716	0.151	0.130	0.130	XXX
(12)		Investment Income Adjustment Factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	XXX	XXX	XXX	XXX
(13)		Composite Underwriting Risk Factor	A1	A1	A1	A1	A2	A2	A2	A3	0.130	0.130	XXX
(14)		Base Underwriting Risk RBC = (4) x (9) x (13)											
(15)		Managed Care Discount Factor*									XXX	XXX	XXX
(16)		RBC After Managed Care Discount = Lines (14) x (15)										XXX	
(17)		Alternate Risk Charge	$500,000	$500,000	$500,000	$500,000	$50,000	$50,000	$50,000	$150,000	$50,000	XXX	XXX
(18)		Net Alternate Risk Charge***	B0	B0	B0	B0	B1	B2	B2	B3	B4	XXX	
(19)		Net Underwriting Risk RBC (MAX{Line (16), Line (18)}) for Columns (1) through (9), Column (10), Line (14)											

Initial Premium Amount‡									
Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement	Vision	Dental	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$25,000,000	$25,000,000	$25,000,000	$25,000,000	$3,000,000	$3,000,000	$3,000,000	$25,000,000	N/A	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

* This row uses the factors calculated on page XR018

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

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† Annual Statement Source

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual	(2) Comprehensive (Hospital & Medical) - Group	(3) Title XVIII - Medicare	(4) Title XIX - Medicaid	(5) Medicare Supplement	(6) Vision Only	(7) Dental Only	(8) Stand-Alone Medicare Part D Coverage	(9) Other Health	(10) Other Non-Health	(11) Total
(1)	Premium	Page 7, Columns 2, Lines 1 + 2	Page 7, Columns 3, Lines 1 + 2	Page 7, Columns 8, Lines 1 + 2	Page 7, Columns 9, Lines 1 + 2	Page 7, Column 4, Line 1 + 2	Page 7, Columns 5, Line 1 + 2	Page 7, Columns 6, Line 1 + 2			Page 7, Column 14, Lines 1 + 2	
(2)	Other Health Risk Revenue	Page 7, Columns 2, Line 4	Page 7, Columns 3, Line 4	Page 7, Columns 8, Line 4	Page 7, Columns 9, Line 4	XXX	Page 7, Columns 5, Line 4	Page 7, Columns 6, Line 4			XXX	
(5)	Net Incurred Claims	Page 7, Columns 2, Line 17	Page 7, Columns 3, Line 17	Page 7, Columns 8, Line 17	Page 7, Columns 9, Line 17	Page 7, Column 4, Line 17	Page 7, Columns 5, Line 17	Page 7, Columns 6, Line 17			XXX	
(7)	Fee-For-Service Offset	Page 7, Columns 2, Line 3	Page 7, Columns 3, Line 3	Page 7, Columns 8, Line 3	Page 7, Columns 9, Line 3	XXX	Page 7, Columns 5, Line 3	Page 7, Columns 6, Line 3			XXX	

Denotes items that must be manually entered on filing software.

XR013 Formulas

Cell Label	Formula
A1	=Line 12 x {Min[Line (4) x Line (10), 25,000,000 x Line (10)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
A2	=Line 12 x {Min[Line (4) x Line (10), 3,000,000 x Line (10)] + Max[0, (Line (4) - 3,000,000) x Line (11)] } / Line (4)
A3	={Min[Line (4) x Line (10), 25,000,000 x Line (10)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
B0	=If[OR[Line (4) > 0, Line (8) > 0], 500,000, 0]
B1	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)], 0]
B2	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)], 0]
B3	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L
B4	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(

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		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Underwriting Risk					
(20)	Business with Rate Guarantees Between 15-36 Months - Direct Premium Earned	Gen Int Part 2 Line 9.21		0.024	
(21)	Business with Rate Guarantees Over 36 Months - Direct Premium Earned	Gen Int Part 2 Line 9.22		0.064	
(22)	FEHBP and TRICARE Claims Incurred	UI, Part 2, Column 7, Line 12.4		0.020	
(23)	Stop Loss and Minimum Premium	Company Records		*	
(24.1)	Supplemental Benefits within Stand-Alone Medicare Part D Coverage (Claims Incurred)	Company Records		0.500	
(24.2)	Medicaid Pass-Through Payments Reported as Premiums	XR013, Column (1), Line (5)		0.020	
(24.3)	Total Other Underwriting Risk	Sum of Lines (20) through (24.2)			
Disability Income Premium					
(25)	Noncancellable Disability Income - Individual Morbidity	Company Records			
(25.1)	First $50 Million Earned Premium of Line (25)			0.350	
(25.2)	Over $50 Million Earned Premium of Line (25)			0.150	
(25.3)	Total Noncancellable Disability Income - Individual Morbidity	Lines (25.1) + (25.2)			
(26)	Other Disability Income - Individual Morbidity	Company Records			
(26.1)	Earned Premium in Line (26) [up to $50 Million less Premium in Line (25.1)]			0.250	
(26.2)	Earned Premium in Line (26) not included in Line (26.1)			0.070	
(26.3)	Total Other Disability Income - Individual Morbidity	Lines (26.1) + (26.2)			
(27)	Disability Income - Credit Monthly Balance Plans	Company Records			
(27.1)	First $50 Million Earned Premium of Line (27)			0.200	
(27.2)	Over $50 Million Earned Premium of Line (27)			0.030	
(27.3)	Total Disability Income - Credit Morbidity	Lines (27.1) + (27.2)			
(28)	Disability Income - Group Long-Term	Company Records			
(28.1)	Earned Premium in Line (28) [up to $50 Million less Premium in Line (27.1)]			0.150	
(28.2)	Earned Premium in Line (28) not included in Line (28.1)			0.030	
(28.3)	Total Disability Income - Group Long-Term	Lines (28.1) + (28.2)			
(29)	Disability Income - Credit Single Premium with Additional Reserves	Company Records			
(29.1)	Additional Reserves for Credit Disability Plans	Company Records			
(29.2)	Additional Reserves for Credit Disability Plans, Prior Year	Company Records			
(29.3)	Sub-Total Disability Income - Credit Single Prem w/Addl Reserves	Lines (29) - (29.1) + (29.2)			
(29.4)	Earned Premium in Line (29.3) [up to $50 Million less Premium in Lines (27.1) + (28.1)]			0.100	
(29.5)	Earned Premium in Line (29.3) not included in Line (29.4)			0.030	
(29.6)	Total Disability Income - Credit Single Premium with Additional Reserves	Lines (29.4) + (29.5)			
(30)	Disability Income - Credit Single Premium without Additional Reserves	Company Records			
(30.1)	Earned Prem in Line (30) [up to $50 Million less Prem in Lines (27.1) + (28.1) + (29.4)]			0.150	
(30.2)	Earned Premium in Line (30) not included in Line (30.1)			0.030	
(30.3)	Total Disability Income - Credit Single Premium without Additional Reserves	Lines (30.1) + (30.2)			
(31)	Disability Income - Group Short-Term	Company Records			
(31.1)	Earned Prem in Line (31) [up to $50 Million less Prem in Lines (27.1) + (28.1) + (29.4) + (30.1)]			0.050	
(31.2)	Earned Premium in Line (31) not included in Line (31.1)			0.030	
(31.3)	Total Disability Income - Group Short-Term	Lines (31.1) + (31.2)			

Denotes items that must be manually entered on filing software.

* A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (23) and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

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Long-Term Care (LTC) Insurance Premium		Annual Statement Source	(1) Amount	Factor		(2) RBC Requirement
(32)	Noncancellable LTC Premium - Rate Risk	Company Records		0.100	*	
(33)	All LTC Premium - Morbidity Risk (to $50 Million)	Line (36.1) Column (1) up to $50 Million		0.100		
(34)	LTC Premium (over $50 Million) - Morbidity Risk	Remainder of Line (36.1) Column (1) over $50 Million		0.030		
(35)	Premium-Based RBC	Column (2), Lines (32) + (33) + (34)				

Historical Loss Ratio Experience		Annual Statement Source	(1) Premiums	(2) Incurred Claims	(3) Column (2)/(1) § Loss Ratio		(4) RBC Requirement
(36.1)	Current Year	Company Records					
(36.2)	Immediate Prior Year	Company Records					
(36.3)	Average Loss Ratio	If loss ratios are used, [Column (3), Line (36.1) + Line (36.2)/2, otherwise zero]					
(37)	Adjusted LTC Claims for RBC	If Column (3) Line (36.3) <> 0, then [Column (1), Line (33) + Line (34)] x Column (3), Line (36.3), else Column (2) Line (36.1)					
(37.1)	Claims (to $35 Million) - Morbidity Risk	Lower of Column (2), Line (37) and $35 Million			0.370	†	
(37.2)	Claims (over $35 Million) - Morbidity Risk	Excess of Column (2), Line (37) over $35 Million			0.120	‡	
(38)	LTC Claims Reserves	Company Records			0.050		
(39)	Claims-Based RBC	Column (4), Lines (37.1) + (37.2)					
(40)	LTC RBC	Column (2), Line (35) + Column (4), Lines (38) + (39)					

* The factor applies to all Noncanellable premium.

† If Column (1), Line (36.1) is positive, then a factor of 0.250 is used. Otherwise, a higher factor of 0.370 is used

‡ If Column (1), Line (36.1) is positive, then a factor of 0.080 is used. Otherwise, a higher factor of 0.120 is used

§ If Column (1), Line (36.1) or (36.2) are less than or equal to zero or if Column (2), Line (36.1) or (36.2) are less than zero, the loss ratios are not used and Column (3), Line (36.3) is set to zero.

Denotes items that must be manually entered on filing software.

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	Limited Benefit Plans (Individual and Group Combined)	Annual Statement Source	(1) Amount	Factor		(2) RBC Requirement
(41)	Hospital Indemnity and Specified Disease	Included in Page 7, Column 13, Line 1 and 2, in part		0.035		
(41.1)	$50,000 if Line (41) is Greater Than Zero					
(41.2)	Total Hospital Indemnity and Specified Disease	Lines (41) + (41.1)				
(42)	Accidental Death & Dismemberment	Included in Page 7, Column 13, Line 1 and 2, in part				
(42.1)	First $10 Million Earned Premium of Line (42)			0.055		
(42.2)	Over $10 Million Earned Premium of Line (42)			0.015		
(42.3)	Maximum Retained Risk for Any Single Claim	Company Records				
(42.4)	Three Times Line (42.3)					
(42.5)	Lesser of Line (42.4) or $300,000					
(42.6)	Total AD&D	Lines (42.1) + (42.2) + (42.5)				
(43)	Other Accident	Included in Page 7, Column 13, Line 1 and 2, in part		0.050		
(44)	Premium Stabilization Reserves	Included in U&I, Part 2D, Column 1, Line 4		-0.500	Φ	
(45)	Total Other Underwriting Risk	Lines (24.3) + (25.3) + (26.3) + (27.3) + (28.3) + (29.6) + (30.3) + (31.3) + (40) + (41.2) + (42.6) + (43) + (44)				

Φ This is limited to the Total Net Underwriting RBC on XR013, Column (11), Line (19) Less Column (8), Line (19) and XR015, Column (2), Lines (24.3), (25.3), (26.3), (27.3), (28.3), (29.6), (30.3), (31.3), XR016 Column (2), Line (35) and XR017 Column (2), Lines (41.2), (42.6), and (43).

Denotes items that must be manually entered on filing software.

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BUSINESS RISK

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Administrative Expense Risk					
(1)	Claims Adjustment Expenses	Page 4, Column 2, Line 20			
(2)	General Administrative Expenses	Page 4, Column 2, Line 21			
(3)	Less the Net Amount of ASC Revenue and Expenses Included in Lines 1 and 2	Company Records			
(4)	Less the Net Amount of ASO Revenue and Expenses Included in Lines 1 and 2	Company Records			
(5)	Less Admin Expenses for Commission & Premium Taxes	Underwriting & Investment Exhibit Part 3, Line 3, in part			
(6)	Administrative Expenses Base RBC	Lines (1) + (2) - (3) - (4) - (5)		*	
(7)	Proration of Admin Expense to Experience Fluctuation Risk	Lines (6) x (20)/(Lines (21) + (22))			
Non-Underwritten and Limited-Risk					
(8)	Administrative Expenses for ASC Arrangements	Company Records		0.020	
(9)	Administrative Expenses for ASO Arrangements	Company Records		0.020	
(10)	Medical Costs Paid Through ASC Arrangements (Including Fee-for Service Received From Other Health Entities)	Company Records		0.010	
(11)	Non-Underwritten and Limited Risk Business RBC				
Guaranty Fund Assessment Risk					
(12)	Premiums Subject to Guaranty Fund Assessment	Included in Sch T - Company Records		0.005	
Excessive Growth Risk					
(13)	UW Risk Revenue, Prior Year	**2025** XR013, Column (7), Line (6) *(manual entry)* †			
(14)	UW Risk Revenue, Current Year	**2026** XR013, Column **(11)**, Line **(4)**			
(15)	Net UW Risk RBC, Prior Year	**2025** XR013, Column (7), Line (21) *(manual entry)* †			
(16)	Net UW Risk RBC, Current Year	**2026** XR013, Column **(11)**, Line **(19)**			
(17)	RBC Growth Safe Harbor	[Lines (14)/(13)+.10] x Line (15)			
(18)	Excess of RBC Growth Over Safe Harbor	Max{0, Lines (16) - (17)}			
(19)	Excessive Growth Risk RBC	.5 x Line (18)			
			Premium	Weight	Weighted Premium
(20)	Experience Fluctuation Risk Revenue	XR013, Column **(11)**, Line **(4)**			
(21)	Premiums Earned	Page 4, Column 2, Lines 2 + 3			
(22)	Risk Revenue	Page 4, Column 2, Line 5			
(23)	Tier 1 - $0 to $25 Million of Line (20)			0.070	
(24)	Tier 2 - Amount Over $25 Million of Line (20)			0.040	
(25)	Total Experience Fluctuation Risk Revenue	Lines (23) + (24)			
(26)	Administrative Expenses Base RBC Factor	Column (2), Line (25) / Column (1), Line (25)			

* The factor for the Administrative Expenses Base RBC is calculated as a weighted average, based on premium volume from XR013.

† For start-up health companies using projected amounts from the domicile state approved proforma, complete Footnote 1.

Denotes items that must be manually entered on filing software.

Footnote 1: If your company is a start-up health company that has received approval from your domiciliary state to use projected amounts in Lines (13) and (15), please explain the projections used.

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CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

			(1) RBC Amount
H0 - INSURANCE AFFILIATES AND MISC. OTHER AMOUNTS			
(1)	Off-Balance Sheet Items	XR005, Off-Balance Sheet Page, Line (21)	
(2)	Directly Owned Health Insurance Companies or Health Entities	XR003, Affiliates Page, Column (2), Line (1)	
(3)	Directly Owned Property and Casualty Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (2)	
(4)	Directly Owned Life Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (3)	
(5)	Indirectly Owned Health Insurance Companies or Health Entities	XR003, Affiliates Page, Column (2), Line (4)	
(6)	Indirectly Owned Property and Casualty Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (5)	
(7)	Indirectly Owned Life Insurance Affiliates	XR003, Affiliates Page, Column (2), Line (6)	
(8)	Affiliated Alien Insurers - Directly Owned	XR003, Affiliates Page, Column (2), Line (9) + (10) + (11)	
(9)	Affiliated Alien Insurers - Indirectly Owned	XR003, Affiliates Page, Column (2), Line (12) + (13) + (14)	
(10)	Total H0	Sum Lines (1) through (9)	
H1 - ASSET RISK - OTHER			
(11)	Holding Company in Excess of Indirect Subs	XR003, Affiliates Page, Column (2), Line (7)	
(12)	Investment Subsidiary	XR003, Affiliates Page, Column (2), Line (8)	
(13)	Investment in Upstream Affiliate (Parent)	XR003, Affiliates Page, Column (2), Line (15)	
(14)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	XR003, Affiliates Page, Column (2), Line (16)	
(15)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	XR003, Affiliates Page, Column (2), Line (17)	
(16)	Directly Owned Life Insurance Companies Not Subject to RBC	XR003, Affiliates Page, Column (2), Line (18)	
(17)	Affiliated Non-Insurer	XR003, Affiliates Page, Column (2), Line (19) + (20) + (21)	
(18)	Fixed Income Assets	XR006, Off-Balance Sheet Collateral, Lines (27) + (37) + (38) + (39) + XR007, Fixed Income Assets - Bonds, Line (27) + XR008, Fixed Income Assets - Miscellaneous, Line (26)	
(19)	Replication & Mandatory Convertible Securities	XR009, Replication/MCS Page, Line (9999999)	
(20)	Unaffiliated Preferred Stock	XR006, Off-Balance Sheet Collateral, Line (34) + XR010, Equity Assets Page, Line (7)	
(21)	Unaffiliated Common Stock & Market Value Excess Affiliated Stocks	XR006, Off-Balance Sheet Collateral, Line (35) + XR010, Equity Assets Page, Line (13)	
(22)	Property & Equipment	XR006, Off-Balance Sheet Collateral, Line (36) + XR011, Prop/Equip Assets Page, Line (9)	
(23)	Asset Concentration	XR012, Grand Total Asset Concentration Page, Line (26)	
(24)	Total H1	Sum Lines (11) through (23)	
H2 - UNDERWRITING RISK			
(25)	Net Underwriting Risk	XR013, Underwriting Risk Page, Line **(19)**	
(26)	Other Underwriting Risk	XR015, Underwriting Risk Page, Line **(24.3)**	
(27)	Disability Income	XR015, Underwriting Risk Page, Lines **(25.3) + (26.3) + (27.3) + (28.3) + (29.6) + (30.3) + (31.3)**	
(28)	Long-Term Care	XR016, Underwriting Risk Page, Line **(40)**	
(29)	Limited Benefit Plans	XR017, Underwriting Risk Page, Lines **(41.2) + (42.6) + (43)**	
(30)	Premium Stabilization Reserve	XR017, Underwriting Risk Page, Line **(44)**	
(31)	Total H2	Sum Lines (25) through (30)	

Denotes items that must be manually entered on filing software.

HEALTH PREMIUMS

		Annual Statement Source	(1) Statement Value		Factor		(2) RBC Requirement
	Medical Insurance Premiums - Individual						
(1)	Comprehensive Medical and Hospital	Earned Premium (Health Supplement Analysis of Operations Column 2 Line 1 + 2)			†		XXX
(2)	Title XVIII Medicare	Earned Premium (Health Supplement Analysis of Operations Column 8 Line 1 + 2 in part)			†		XXX
(3)	Title XIX Medicaid	Earned Premium (Health Supplement Analysis of Operations Column 9 Line 1 + 2 in part)			†		XXX
(4)	Medicare Supplement	Earned Premium (Health Supplement Analysis of Operations Column 4 Line 1 + 2 in part)			†		XXX
(5)	Vision Only	Earned Premium (Health Supplement Analysis of Operations Column 5 Line 1 + 2 in part)			†		XXX
(6)	Dental Only	Earned Premium (Health Supplement Analysis of Operations Column 6 Line 1 + 2 in part)			†		XXX
(7)	Stand-Alone Medicare Part D Coverage	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)			†		XXX
(8)	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)	Company Records		X	0.500	=	
(9)	Medicaid Pass-Through Payments Reported as Premium	Company Records		X	0.020	=	
(10)	Hospital Indemnity and Specified Disease	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	*	=	
(11)	AD&D (Maximum Retained Risk Per Life)	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	‡	=	
(12)	Other Accident	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	0.050	=	
	Medical Insurance Premiums - Group and Credit						
(13)	Comprehensive Medical and Hospital	Earned Premium (Health Supplement Analysis of Operations Column 3 Line 1 + 2)			†		XXX
(14)	Title XVIII Medicare	Earned Premium (Health Supplement Analysis of Operations Column 8 Line 1 + 2 in part)			†		XXX
(15)	Title XIX Medicaid	Earned Premium (Health Supplement Analysis of Operations Column 9 Line 1 + 2 in part)			†		XXX
(16)	Vision Only	Earned Premium (Health Supplement Analysis of Operations Column 5 Line 1 + 2 in part)			†		XXX
(17)	Dental Only	Earned Premium (Health Supplement Analysis of Operations Column 6 Line 1 + 2 in part)			†		XXX
(18)	Stop Loss and Minimum Premium	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	¥	=	
(19)	Medicare Supplement	Earned Premium (Health Supplement Analysis of Operations Column 4 Line 1 + 2 in part)			†		XXX
(20)	Stand-Alone Medicare Part D Coverage (see instructions for limits)	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)			†		XXX
(21)	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)	Company Records		X	0.500	=	
(22)	Medicaid Pass-Through Payments Reported as Premium	Company Records		X	0.020	=	
(23)	Hospital Indemnity and Specified Disease	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	*	=	
(24)	AD&D (Maximum Retained Risk Per Life)	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	‡	=	
(25)	Other Accident	Earned Premium (Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	0.050	=	
(26)	Federal Employee Health Benefit Plan	Earned Premium (Health Supplement Column 7 Line 1 + 2)		X	0.000	=	
	Disability Income Premium						
(27)	Noncancellable Disability Income - Individual Morbidity	Earned Premium (Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(28)	Other Disability Income - Individual Morbidity	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(29)	Disability Income - Credit Monthly Balance Plans	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(30)	Disability Income - Group Long-Term	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(31)	Disability Income-Credit Single Premium with Additional Reserves	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(32)	Disability Income-Credit Single Premium without Additional Reserves	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(33)	Disability Income - Group Short-Term	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2 in part)		X	‡	=	
(34)	Total Disability Income	Earned Premium Health Supplement Analysis of Operations Column 11 Line 1 + 2)					
	Long-Term Care						
(35)	Noncancellable Long-Term Care Premium - Rate Risk**	Earned Premium Health Supplement Analysis of Operations Column 12 Line 1 + 2 in part)		X	0.127**	=	
(36)	Other Long-Term Care Premium ‡‡	Earned Premium Health Supplement Analysis of Operations Column 12 Line 1 + 2 in part)		X	0.000	=	‡‡
(37)	Total Long Term Care	Earned Premium Health Supplement Analysis of Operations Column 12 Line 1 + 2)					
	Health Premium With Limited Underwriting Risk						
(38)	ASC Business Reported as Revenue Premium	Earned Premium Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	0.000	=	
	Other Health						
(39)	Workers Compensation Carve-Out	Earned Premium Health Supplement Analysis of Operations Column 13 Line 1 + 2 in part)		X	0.000	=	
(40)	Other Health	Earned Premium Health Supplement Analysis of Operations Column 10 and 13 Line 1 + 2 in part)		X	0.120	=	
(41)	Total Earned Premiums	Sum of Lines (1) through (26) excluding (9) and (22); Line (34); and Line (37) through (40)					
	(Column (1) should equal sum of Health Supplement Analysis of Operations Columns 2 through 13 Line 1 + 2)						
(42)	Additional Reserves for Credit Disability Plans	Exhibit 6, Column 10, Line 2		§			
(43)	Additional Reserves for Credit Disability Plans, prior year	Exhibit 6, Column 10, Line 2, prior year		§			

† The premium amounts in these lines are transferred to LR020 Underwriting Risk – Experience Fluctuation Risk Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete LR022 Underwriting Risk – Managed Care Credit. In which case, the company will also need to complete LR028 Health Credit Risk in the (C-3) portion of the formula. If there are amounts in any of lines (1) through (6), (13) through (17), or (19) on page LR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of LR029 Business Risk in the (C-4) portion of the formula.

‡ The two tiered calculation is illustrated in the risk-based capital instructions for LR019 Health Premiums.

‡‡ The balance of the RBC requirement for Long Term Care - Morbidity Risk is calculated on page LR023. The premium is shown to allow totals to check to Health Supplement Analysis of Operations.

* If there is premium included on either or both of these lines, the RBC requirement in Column (2) will include 3.5 percent of such premium and $50,000 (included in the line with the larger premium).

** The factor applies to all Noncancellable premium.

§ These amounts are used to adjust the premium base for single premium credit disability plans that carry additional tabular reserves.

¥ A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (12) and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

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

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UNDERWRITING RISK

Experience Fluctuation Risk

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual	(2) Comprehensive (Hospital & Medical) - Group	(3) Title XVIII - Medicare	(4) Title XIX - Medicaid	(5) Medicare Supplement	(6) Vision Only	(7) Dental Only	(8) Stand-Alone Medicare Part D Coverage	(9) Total
(1.1)	Individual Premium †		XXX							
(1.2)	Group Premium †	XXX								
(1.3)	Total Premium† (1.1) + (1.2)									
(2)	Other Health Risk Rev†					XXX				
(3)	Medicaid Pass-Through Payments Reported as Premiums	XXX	XXX	XXX		XXX	XXX	XXX	XXX	
(4)	Underwriting Risk Revenue (1.3) + (2) - (3)									
(5)	Net Incured Claims†									
(6)	Medicaid Pass-Through Payments Reported as Claims	XXX	XXX	XXX		XXX	XXX	XXX	XXX	
(7)	Fee-For-Service Offset†					XXX				
(8)	Underwring Risk Incurred Claims (5) - (6) - (7)									
(9)	Underwriting Risk Claim Ratio (8)/(4)									XXX
(10)	Underwriting Risk Factor for Intial Amounts of Premium‡	0.1440	0.1440	0.1440	0.1440	0.0987	0.1153	0.1153	0.251	XXX
(11)	Underwriting Risk Factor for Excess of Intial Amount‡	0.0844	0.0844	0.0844	0.0844	0.0609	0.0716	0.0716	0.151	XXX
(12)	Investment Income Adjustment Factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	XXX	
(13)	Composite Underwriting Risk Factor	A1	A1	A1	A1	A2	A2	A2	A3	XXX
(14)	Base Underwriting Risk RBC = (4) x (9) x (13)									
(15)	Managed Care Discount Factor (LR022 Line 17)									XXX
(16)	RBC After Managed Care Discount = Lines (14) x (15)									
(17)	Alternate Risk Charge	$500,000	$500,000	$500,000	$500,000	$50,000	$50,000	$50,000	$150,000	
(18)	Net Alternate Risk Charge	B0	B0	B0	B0	B1	B2	B2	B3	
(19)	Net Underwriting Risk RBC (MAX{Line (16), Line (18)})									

† **The Annual Statement Sources are found on page LR020-A.**

Initial Premium Amount‡							
Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement	Vision	Dental	Stand-Alone Medicare Part D Coverage
$25,000,000	$25,000,000	$25,000,000	$25,000,000	$3,000,000	$3,000,000	$3,000,000	$25,000,000

~~‡ The Line (17) Alternate Risk Charge is calculated as follows:~~

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

† Annual Statement Source

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual	(2) Comprehensive (Hospital & Medical) - Group	(3) Title XVIII - Medicare	(4) Title XIX - Medicaid	(5) Medicare Supplement	(6) Vision Only	(7) Dental Only	(8) Stand-Alone Medicare Part D Coverage	(11) Total
(1.3)	Premium	Health Supp Analysis of Operations, Columns 2, Lines 1 + 2	Health Supp Analysis of Operations, Columns 3, Lines 1 + 2	Health Supp Analysis of Operations, Columns 8, Lines 1 + 2	Health Supp Analysis of Operations, Columns 9, Lines 1 + 2	Health Supp Analysis of Operations, Column 4, Line 1 + 2	Health Supp Analysis of Operations, Columns 5, Line 1 + 2	Health Supp Analysis of Operations, Columns 6, Line 1 + 2		
(2)	Other Health Risk Revenue	Health Supp Analysis of Operations, Columns 2, Line 4	Health Supp Analysis of Operations, Columns 3, Line 4	Health Supp Analysis of Operations, Columns 8, Line 4	Health Supp Analysis of Operations, Columns 9, Line 4	XXX	Health Supp Analysis of Operations, Columns 5, Line 4	Health Supp Analysis of Operations, Columns 6, Line 4		
(5)	Net Incurred Claims	Health Supp Analysis of Operations, Columns 2, Line 17	Health Supp Analysis of Operations, Columns 3, Line 17	Health Supp Analysis of Operations, Columns 8, Line 17	Health Supp Analysis of Operations, Columns 9, Line 17	Analysis of Operations, Column 4, Line 17	Health Supp Analysis of Operations, Columns 5, Line 17	Health Supp Analysis of Operations, Columns 6, Line 17		
(7)	Fee-For-Service Offset	Health Supp Analysis of Operations, Columns 2, Line 3	Health Supp Analysis of Operations, Columns 3, Line 3	Health Supp Analysis of Operations, Columns 8, Line 3	Health Supp Analysis of Operations, Columns 9, Line 3	XXX	Health Supp Analysis of Operations, Columns 5, Line 3	Health Supp Analysis of Operations, Columns 6, Line 3		

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

LR020 Formulas

Cell Lab	Formula
A1	=Line 12 x {Min[Line (4) x Line (10), 25,000,000 x Line (10)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
A2	=Line 12 x {Min[Line (4) x Line (10), 3,000,000 x Line (10)] + Max[0, (Line (4) - 3,000,000) x Line (11)] } / Line (4)
A3	={Min[Line (4) x Line (10), 25,000,000 x Line (10)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
B0	=If[OR[Line (4) > 0, Line (8) > 0], 500,000, 0]
B1	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)], 0]
B2	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)], 0]
B3	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(18) - C(7) L(18)], 0]

HEALTH CLAIMS RESERVES

		Annual Statement Source	(1) Statement Value	(2) Less Workers Compensation Carve Out	(3) RBC Subtotal	Factor	(4) RBC Requirement
	Individual Claim Reserves						
(1)	Exhibit 6 Total Individual Claim Reserves	Company Records					
(2)	Line is to be left blank or zero-filled for **2025**						
(3)	Line is to be left blank or zero-filled for **2025**						
(4)	Line is to be left blank or zero-filled for **2025**						
(5)	Line is to be left blank or zero-filled for **2025**						
(6)	Line is to be left blank or zero-filled for **2025**						
(7)	Modified Coinsurance Assumed Reserves	Schedule S Part 1 Section 2 Column 12, in part †					
(8)	Less Modified Coinsurance Ceded Reserves	Schedule S Part 3 Section 2 Column 13, in part †					
(9)	Disability Income and Long-Term Care Claim Reserves	Company Records				X 0.063 =	
(10)	Total Individual Claim Reserves	Lines (1) + (2) + (3) + (4) + (5) + (6) + (7) - (8) - (9)				X 0.050 =	
	Group and Credit Claim Reserves						
(11)	Exhibit 6 Total Group & Credit Claim Reserves	Company Records					
(12)	Line is to be left blank or zero-filled for **2025**						
(13)	Modified Coinsurance Assumed Reserves	Schedule S Part 1 Section 2 Column 12, in part †					
(14)	Less Modified Coinsurance Ceded Reserves	Schedule S Part 3 Section 2 Column 13, in part †					
(15)	Disability Income and Long-Term Care Claim Reserves	Company Records				X 0.063 =	
(16)	Total Exhibit 6 Group and Credit Claim Reserves	Lines (11) + (12) + (13) - (14) - (15)				X 0.050 =	
(17)	Total Claim Reserves	Lines (9) + (10) + (15) + (16)					
(18)	Total Health RBC	LR019 Health Premiums Column (2) Line **(41)** + LR020 Underwriting Risk Experience Fluctuation Risk Column **(9)** Line **(19)** + LR021 Underwriting Risk Other Column (2) Line (7) + LR023 Long-Term Care Morbidity Risk Column (4) Line (7) + LR024 Health Claim Reserves Column (4) Line (17)					

† Include only the portion which relates to claim reserves that, if written on a direct basis, would be included on Exhibit 6.

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

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PREMIUM STABILIZATION RESERVES

		Annual Statement Source	(1) Statement Value		Factor		(2) RBC Requirement
	Group and Credit Life and Health Reported Premium Stabilization Reserves						
(1)	Stabilization Reserves and Experience Rating Refunds included in Line 3	Page 3 Column 1 Line 3 in part		X	0.500	=	
(2)	Provision for Experience Rating Refunds	Page 3 Column 1 Line 9.2 in part		X	0.500	=	
(3)	Reserve for Group Rate Credits	Company Records		X	0.500	=	
(4)	Reserve for Credit Rate Credits	Company Records		X	0.500	=	
(5)	Premium Stabilization Reserves	Page 3 Column 1 Line 25 in part		X	0.500	=	
(6)	Total of Preliminary Premium Stabilization Reserve Credit	Sum of Lines (1) through (5)					
	Group & Credit Life and Health Risk-Based Capital						
(7)	Life	LR025 Life Insurance Column (2) Line (12)					
(8)	Health	LR024 Health Claim Reserves Column (4) Line (16) + [LR024 Column (4) Line (15) x 0.65] + LR019 Health Premiums Column (2) Lines **(18), (23), (24)** and **(25)** + [[LR019 Column (2) Lines **(29), (30),** and **(33)**] x 0.65] + [LR020 Underwriting Risk - Experience Fluctuation Risk Column **(9)** Line **(19)** - Column **(8)** Line **(19)** x **Column 9** Line (1.2) / (1.3)]					
(9)	Maximum Risk-Based Capital	Lines (7) + (8)					
(10)	Final Premium Stabilization Reserve	Column (2) Line (6), but not more than Column (1) Line (9)		X	-1.000	=	

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

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BUSINESS RISK

		Annual Statement Source	(1) Statement Value	Factor	(2) RBC Requirement
	Life Insurance Premiums				
(1)	Total Life Premiums	Schedule T Column 2 Line 59			
(2)	Less American Samoa Life Premiums	Schedule T Column 2 Line 52			
(3)	Less Guam Life Premiums	Schedule T Column 2 Line 53			
(4)	Less Puerto Rico Life Premiums	Schedule T Column 2 Line 54			
(5)	Less U.S. Virgin Islands Life Premiums	Schedule T Column 2 Line 55			
(6)	Less Northern Mariana Islands Life Premiums	Schedule T Column 2 Line 56			
(7)	Less Canada Life Premiums	Schedule T Column 2 Line 57			
(8)	Less Other Alien Life Premiums	Schedule T Column 2 Line 58			
(9)	Subtotal Net Life Premiums	Line (1) less the Sum of Lines (2) through (8)			
(10)	Plus Foreign Variable and Other Life Premiums	See Instructions†			
(11)	Less Total Variable and Other Life Premiums	See Instructions†			
(12)	Net Life Premiums	Line (9) plus Line (10) less Line (11)		X 0.0253 =	
	Annuity Considerations				
(13)	Total Annuity Considerations	Schedule T Column 3 Line 59			
(14)	Less American Samoa Annuity Considerations	Schedule T Column 3 Line 52			
(15)	Less Guam Annuity Considerations	Schedule T Column 3 Line 53			
(16)	Less Puerto Rico Annuity Considerations	Schedule T Column 3 Line 54			
(17)	Less U.S. Virgin Islands Annuity Considerations	Schedule T Column 3 Line 55			
(18)	Less Northern Mariana Islands Annuity Considerations	Schedule T Column 3 Line 56			
(19)	Less Canada Annuity Considerations	Schedule T Column 3 Line 57			
(20)	Less Other Alien Annuity Considerations	Schedule T Column 3 Line 58			
(21)	Subtotal Net Annuity Considerations	Line (13) less the Sum of Lines (14) through (20)			
(22)	Plus Foreign Variable and Other Annuity Considerations	See Instructions†			
(23)	Less Total Variable and Other Annuity Considerations	See Instructions†			
(24)	Net Annuity Considerations	Line (21) plus Line (22) less Line (23)		X 0.0253 =	
	Accident and Health Premiums				
(25)	Total Accident and Health Premiums	Schedule T Column 4 Line 59			
(26)	Less American Samoa Accident and Health Premiums	Schedule T Column 4 Line 52			
(27)	Less Guam Accident and Health Premiums	Schedule T Column 4 Line 53			
(28)	Less Puerto Rico Accident and Health Premiums	Schedule T Column 4 Line 54			
(29)	Less U.S. Virgin Islands Accident and Health Premiums	Schedule T Column 4 Line 55			
(30)	Less Northern Mariana Islands Accident and Health Premiums	Schedule T Column 4 Line 56			
(31)	Less Canada Accident and Health Premiums	Schedule T Column 4 Line 57			
(32)	Less Other Alien Accident and Health Premiums	Schedule T Column 4 Line 58			
(33)	Subtotal Net Accident and Health Premiums	Line (25) less the Sum of Lines (26) through (32)			
(34)	Plus Foreign Variable and Other A&H Premiums	See Instructions†			
(35)	Less Total Variable and Other A&H Premiums	See Instructions†			
(36)	Net Accident and Health Premiums	Line (33) plus Line (34) less Line (35)		X 0.0063 =	

† Enter amounts only if included in Schedule T Column 2 (life), Column 3 (annuity) or Column 4 (accident and health).

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

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BUSINESS RISK (CONTINUED)

		Annual Statement Source	(1) Statement Value		Factor		(2) RBC Requirement
	Separate Account Liabilities						
(37)	Total Liabilities from Separate Accounts Statement	Page 3 Column 1 Line 27					
(38)	Transfers to Separate Accounts Due or Accrued	Page 3 Column 1 Line 13					
(39)	Total Separate Account Liabilities	Line (37) plus Line (38)		X	0.0006	=	
(40)	Business Risk (C-4a)	Lines (12) + (24) + (36) + (39)					
	Administrative Expenses for Certain A&H Coverages						
(41)	Total Accident and Health Premiums	LR019 Health Premiums Column (1) Line **(41)**					
(42)	Accident and Health Premiums from Underwriting Risk	LR020 Underwriting Risk Column **(9) Line (1.3)**					
(43)	Accident and Health Premiums Factor	Line (42) / Line (41)					
(44)	Exhibit 2 Administrative Expenses for Health Insurance	Exhibit 2 Column 2 + Column 3 Line 10					
(45)	Exhibit 3 Administrative Expenses for Health Insurance	Exhibit 3 Column 2 Line 7					
(46)	Less Administrative Expenses for Administrative Service Contracts (ASC)	Included in Exhibit 2 Col. 2 + Col. 3 and Exhibit 3 Col. 2					
(47)	Less Administrative Expenses for Administrative Services Only (ASO) Business	Included in Exhibit 2 Col. 2 + Col. 3 and Exhibit 3 Col. 2					
(48)	Less Administrative Expenses for Commissions and Premium Taxes	Included in Exhibit 2 Col. 2 + Col. 3 and Exhibit 3 Col. 2					
(49)	Net Administrative Expenses	Lines (44) + (45) - (46) - (47) - (48)					
(50)	Composite Health Administrative Expense Risk Factor	(7% of Line (42) up to $25 million + 4% of any in excess of $25 million)/Line (42)					
(51)	Administrative Expense Component for Health	Line (49) x factor Line (43) x factor Line (50)					
	Health ASO/ASC						
(52)	Administrative Expenses for ASC Business	Company Records§		X	0.0200	=	
(53)	Administrative Expenses for ASO Business	Company Records§		X	0.0200	=	
(54)	ASC Claims Reported as Incurred Claims	Company Records		X	0.0100	=	
(55)	Other Medical Costs Paid through ASC Arrangements	Company Records		X	0.0100	=	
(56)	Fee-for-Service Received from Health Entities	Company Records		X	0.0100	=	
(57)	Business Risk (C-4b)	Column (2) Lines (51) + (52) + (53) + (54) + (55) + (56)					

§ Line (52) should be greater than or equal to Line (46). Line (53) should be greater than or equal to Line (47).

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

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CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL

		Source	(1) RBC Amount		Tax Factor		(2) RBC Tax Effect	
	ASSET RISKS							
	Bonds							
(001)	Long-term Bonds – NAIC 1	LR002 Bonds Column (2) Line (2.8) + LR018 Off-Balance Sheet Collateral Column (3) Line (2.8)		X	0.1680	=		
(002)	Long-term Bonds – NAIC 2	LR002 Bonds Column (2) Line (3.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (3.4)		X	0.1680	=		
(003)	Long-term Bonds – NAIC 3	LR002 Bonds Column (2) Line (4.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (4.4)		X	0.1680	=		
(004)	Long-term Bonds – NAIC 4	LR002 Bonds Column (2) Line (5.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (5.4)		X	0.1680	=		
(005)	Long-term Bonds – NAIC 5	LR002 Bonds Column (2) Line (6.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (6.4)		X	0.1680	=		
(006)	Long-term Bonds – NAIC 6	LR002 Bonds Column (2) Line (7) + LR018 Off-Balance Sheet Collateral Column (3) Line (7)		X	0.2100	=		
(007)	Short-term Bonds – NAIC 1	LR002 Bonds Column (2) Line (10.8)		X	0.1680	=		
(008)	Short-term Bonds – NAIC 2	LR002 Bonds Column (2) Line (11.4)		X	0.1680	=		
(009)	Short-term Bonds – NAIC 3	LR002 Bonds Column (2) Line (12.4)		X	0.1680	=		
(010)	Short-term Bonds – NAIC 4	LR002 Bonds Column (2) Line (13.4)		X	0.1680	=		
(011)	Short-term Bonds – NAIC 5	LR002 Bonds Column (2) Line (14.4)		X	0.1680	=		
(012)	Short-term Bonds – NAIC 6	LR002 Bonds Column (2) Line (15)		X	0.2100	=		
(013)	Credit for Hedging - NAIC 1 Through 5 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0199999)		X	0.1680	=		†
(014)	Credit for Hedging - NAIC 6 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0299999)		X	0.2100	=		†
(015)	Bond Reduction - Reinsurance	LR002 Bonds Column (2) Line (19)		X	0.2100	=		†
(016)	Bond Increase - Reinsurance	LR002 Bonds Column (2) Line (20)		X	0.2100	=		
(017)	Non-Exempt NAIC 1 U.S. Government Agency	LR002 Bonds Column (2) Line (22)		X	0.1680	=		
(018)	Bonds Size Factor	LR002 Bonds Column (2) Line (26) - LR002 Bonds Column (2) Line (21)		X	0.1680	=		
	Mortgages							
	In Good Standing							
(019)	Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (1)		X	0.1575	=		
(020)	Residential Mortgages - Other	LR004 Mortgages Column (6) Line (2)		X	0.1575	=		
(021)	Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (3)		X	0.1575	=		
(022)	Total Commercial Mortgages - All Other	LR004 Mortgages Column (6) Line (9)		X	0.1575	=		
(023)	Total Farm Mortgages	LR004 Mortgages Column (6) Line (15)		X	0.1575	=		
	90 Days Overdue							
(024)	Farm Mortgages	LR004 Mortgages Column (6) Line (16)		X	0.1575	=		
(025)	Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (17)		X	0.1575	=		
(026)	Residential Mortgages - Other	LR004 Mortgages Column (6) Line (18)		X	0.1575	=		
(027)	Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (19)		X	0.1575	=		
(028)	Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (20)		X	0.1575	=		
	In Process of Foreclosure							
(029)	Farm Mortgages	LR004 Mortgages Column (6) Line (21)		X	0.1575	=		

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

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

		Source	(1) RBC Amount		Tax Factor		(2) RBC Tax Effect	
(030)	Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (22)		X	0.1575	=		
(031)	Residential Mortgages - Other	LR004 Mortgages Column (6) Line (23)		X	0.1575	=		
(032)	Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (24)		X	0.1575	=		
(033)	Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (25)		X	0.1575	=		
(034)	Due & Unpaid Taxes Mortgages	LR004 Mortgages Column (6) Line (26)		X	0.1575	=		
(035)	Due & Unpaid Taxes - Foreclosures	LR004 Mortgages Column (6) Line (27)		X	0.1575	=		
(036)	Mortgage Reduction - Reinsurance	LR004 Mortgages Column (6) Line (29)		X	0.2100	=		†
(037)	Mortgage Increase - Reinsurance	LR004 Mortgages Column (6) Line (30)		X	0.2100	=		
	Preferred Stock							
(038)	Unaffiliated Preferred Stock NAIC 1	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (1) + LR018 Off-Balance Sheet Collateral Column (3) Line (9)		X	0.1575	=		
(039)	Unaffiliated Preferred Stock NAIC 2	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (2) + LR018 Off-Balance Sheet Collateral Column (3) Line (10)		X	0.1575	=		
(040)	Unaffiliated Preferred Stock-NAIC 3	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (3) + LR018 Off-Balance Sheet Collateral Column (3) Line (11)		X	0.1575	=		
(041)	Unaffiliated Preferred Stock NAIC 4	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (4) + LR018 Off-Balance Sheet Collateral Column (3) Line (12)		X	0.1575	=		
(042)	Unaffiliated Preferred Stock NAIC 5	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (5) + LR018 Off-Balance Sheet Collateral Column (3) Line (13)		X	0.1575	=		
(043)	Unaffiliated Preferred Stock NAIC 6	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (6) + LR018 Off-Balance Sheet Collateral Column (3) Line (14)		X	0.2100	=		
(044)	Preferred Stock Reduction-Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (8)		X	0.2100	=		†
(045)	Preferred Stock Increase-Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (9)		X	0.2100	=		
	Separate Accounts							
(046)	Guaranteed Index	LR006 Separate Accounts Column (3) Line (1)		X	0.1575	=		
(047)	Nonindex-Book Reserve	LR006 Separate Accounts Column (3) Line (2)		X	0.1575	=		
(048)	Separate Accounts Nonindex-Market Reserve	LR006 Separate Accounts Column (3) Line (3)		X	0.1575	=		
(049)	Separate Accounts Reduction-Reinsurance	LR006 Separate Accounts Column (3) Line (5)		X	0.2100	=		†
(050)	Separate Accounts Increase-Reinsurance	LR006 Separate Accounts Column (3) Line (6)		X	0.2100	=		
(051)	Synthetic GICs	LR006 Separate Accounts Column (3) Line (8)		X	0.1575	=		
(052)	Separate Account Surplus	LR006 Separate Accounts Column (3) Line (13)		X	0.1575	=		
	Real Estate							
(053)	Company Occupied Real Estate	LR007 Real Estate Column (3) Line (3)		X	0.2100	=		
(054)	Foreclosed Real Estate	LR007 Real Estate Column (3) Line (6)		X	0.2100	=		
(055)	Investment Real Estate	LR007 Real Estate Column (3) Line (9)		X	0.2100	=		
(056)	Real Estate Reduction - Reinsurance	LR007 Real Estate Column (3) Line (11)		X	0.2100	=		†
(057)	Real Estate Increase - Reinsurance	LR007 Real Estate Column (3) Line (12)		X	0.2100	=		
	Schedule BA							
(058)	Sch BA Real Estate Excluding Tax Credit Investments	LR007 Real Estate Column (3) Line (16)		X	0.2100	=		
(059)	Yield Guaranteed State Tax Credit Investments	LR007 Real Estate Column (3) Line (17)		X	0.0000	=		
(060)	Qualifying and Other Tax Credit Investments	LR007 Real Estate Column (3) Line (18) + Line (19) + Line (20)		X	0.0000	=		
(061)	Sch BA Real Estate Reduction - Reinsurance	LR007 Real Estate Column (3) Line (23)		X	0.2100	=		†
(062)	Sch BA Real Estate Increase - Reinsurance	LR007 Real Estate Column (3) Line (24)		X	0.2100	=		

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

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

		Source	(1) RBC Amount		Tax Factor		(2) RBC Tax Effect	
(063)	Sch BA Bond NAIC 1	LR008 Other Long-Term Assets Column (5) Line (2)		X	0.1575	=		
(064)	Sch BA Bond NAIC 2	LR008 Other Long-Term Assets Column (5) Line (3)		X	0.1575	=		
(065)	Sch BA Bond NAIC 3	LR008 Other Long-Term Assets Column (5) Line (4)		X	0.1575	=		
(066)	Sch BA Bond NAIC 4	LR008 Other Long-Term Assets Column (5) Line (5)		X	0.1575	=		
(067)	Sch BA Bond NAIC 5	LR008 Other Long-Term Assets Column (5) Line (6)		X	0.1575	=		
(068)	Sch BA Bond NAIC 6	LR008 Other Long-Term Assets Column (5) Line (7)		X	0.2100	=		
(069)	BA Bond Reduction - Reinsurance	LR008 Other Long-Term Assets Column (5) Line (9)		X	0.2100	=		†
(070)	BA Bond Increase - Reinsurance	LR008 Other Long-Term Assets Column (5) Line (10)		X	0.2100	=		
(071)	BA Preferred Stock NAIC 1	LR008 Other Long-Term Assets Column (5) Line (12)		X	0.1575	=		
(072)	BA Preferred Stock NAIC 2	LR008 Other Long-Term Assets Column (5) Line (13)		X	0.1575	=		
(073)	BA Preferred Stock NAIC 3	LR008 Other Long-Term Assets Column (5) Line (14)		X	0.1575	=		
(074)	BA Preferred Stock NAIC 4	LR008 Other Long-Term Assets Column (5) Line (15)		X	0.1575	=		
(075)	BA Preferred Stock NAIC 5	LR008 Other Long-Term Assets Column (5) Line (16)		X	0.1575	=		
(076)	BA Preferred Stock NAIC 6	LR008 Other Long-Term Assets Column (5) Line (17)		X	0.2100	=		
(077)	BA Preferred Stock Reduction-Reinsurance	LR008 Other Long-Term Assets Column (5) Line (19)		X	0.2100	=		†
(078)	BA Preferred Stock Increase - Reinsurance	LR008 Other Long-Term Assets Column (5) Line (20)		X	0.2100	=		
(079)	Rated Surplus Notes	LR008 Other Long-Term Assets Column (5) Line (31)		X	0.1575	=		
(080)	Rated Capital Notes	LR008 Other Long-Term Assets Column (5) Line (41)		X	0.1575	=		
(081)	BA Common Stock Affiliated	LR008 Other Long-Term Assets Column (5) Line (50.3)		X	0.2100	=		
(082)	BA Collateral Loans	LR008 Other Long-Term Assets Column (5) Line (51)		X	0.1575	=		
(083)	Other BA Assets	LR008 Other Long-Term Assets Column (5) Line (53.3) + LR018 Off-Balance Sheet Collateral Column (3) Line (17) + Line (18)		X	0.2100	=		
(084)	Other BA Assets Reduction-Reinsurance	LR008 Other Long-Term Assets Column (5) Line (55)		X	0.2100	=		†
(085)	Other BA Assets Increase - Reinsurance	LR008 Other Long-Term Assets Column (5) Line (56)		X	0.2100	=		
(086)	BA Mortgages - In Good Standing	LR009 Schedule BA Mortgages Column (6) Line (12)		X	0.1575	=		
(087)	BA Mortgages - 90 Days Overdue	LR009 Schedule BA Mortgages Column (6) Line (16)		X	0.1575	=		
(088)	BA Mortgages - In Process of Foreclosure	LR009 Schedule BA Mortgages Column (6) Line (20)		X	0.1575	=		
(089)	Reduction - Reinsurance	LR009 Schedule BA Mortgages Column (6) Line (22)		X	0.2100	=		†
(090)	Increase - Reinsurance	LR009 Schedule BA Mortgages Column (6) Line (23)		X	0.2100	=		
	Miscellaneous							
(091)	Asset Concentration Factor	LR010 Asset Concentration Factor Column (6) Line (61) Grand Total Page		X	0.1575	=		
(092)	Miscellaneous Assets	LR012 Miscellaneous Assets Column (2) Line (7)		X	0.1575	=		
(093)	Derivatives - Collateral and Exchange Traded	LR012 Miscellaneous Assets Column (2) Lines (8) + (9) + (10)		X	0.1575	=		
(094)	Derivatives NAIC 1	LR012 Miscellaneous Assets Column (2) Line (11)		X	0.1575	=		
(095)	Derivatives NAIC 2	LR012 Miscellaneous Assets Column (2) Line (12)		X	0.1575	=		
(096)	Derivatives NAIC 3	LR012 Miscellaneous Assets Column (2) Line (13)		X	0.1575	=		
(097)	Derivatives NAIC 4	LR012 Miscellaneous Assets Column (2) Line (14)		X	0.1575	=		
(098)	Derivatives NAIC 5	LR012 Miscellaneous Assets Column (2) Line (15)		X	0.1575	=		
(099)	Derivatives NAIC 6	LR012 Miscellaneous Assets Column (2) Line (16)		X	0.2100	=		
(100)	Miscellaneous Assets Reduction-Reinsurance	LR012 Miscellaneous Assets Column (2) Line (19)		X	0.2100	=		†
(101)	Miscellaneous Assets Increase-Reinsurance	LR012 Miscellaneous Assets Column (2) Line (20)		X	0.2100	=		

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CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

		Source	(1) RBC Amount		Tax Factor		(2) RBC Tax Effect	
(102)	Replications	LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (9999999)		X	0.1575	=		
(103)	Reinsurance	LR016 Reinsurance Column (4) Line (17)		X	0.2100	=		
(104)	Investment Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (8)		X	0.2100	=		
(105)	Investment in Upstream Affiliate (Parent)	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (15)		X	0.2100	=		
(106)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (16)		X	0.2100	=		
(107)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (17)		X	0.2100	=		
(108)	Directly Owned Life Insurance Companies Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (18)		X	0.2100	=		
(109)	Publicly Traded Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (22)		X	0.2100	=		
(110)	Subtotal for C-1o Assets	Sum of Lines (001) through (109), Recognizing the Deduction of Lines (013), (014), (015), (036), (044), (049), (056), (061), (069), (077), (084), (089) and (100)						
	C-0 Affiliated Common Stock							
(111)	Off-Balance Sheet and Other Items	LR017 Off-Balance Sheet and Other Items Column (5) Line (27)		X	0.1575	=		
(112)	Off-Balance Sheet Items Reduction - Reinsurance	LR017 Off-Balance Sheet and Other Items Column (5) Line (28)		X	0.2100	=		†
(113)	Off-Balance Sheet Items Increase - Reinsurance	LR017 Off-Balance Sheet and Other Items Column (5) Line (29)		X	0.2100	=		
(114)	Directly Owned Health Insurance Companies or Health Entities	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (1)		X	0.2100	=		
(115)	Directly Owned Property and Casualty Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (2)		X	0.2100	=		
(116)	Directly Owned Life Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (3)		X	0.2100	=		
(117)	Indirectly Owned Health Insurance Companies or Health Entities	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (4)		X	0.2100	=		
(118)	Indirectly Owned Property and Casualty Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (5)		X	0.2100	=		
(119)	Indirectly Owned Life Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (6)		X	0.2100	=		
(120)	Affiliated Alien Insurers - Directly Owned	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (9) + (10) + (11)		X	0.0000	=		
(121)	Affiliated Alien Insurers - Indirectly Owned	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (12) + (13) + (14)		X	0.0000	=		
(122)	Subtotal for C-0 Affiliated Common Stock	Lines (111)-(112)+(113)+(114)+(115)+(116)+(117)+(118)+(119)+(120)+(121)						
	Common Stock							
(123)	Unaffiliated Common Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (17) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)		X	0.2100	=		
(124)	Credit for Hedging - Common Stock	LR015 Hedged Asset Common Stock Schedule Column (10) Line (0299999)		X	0.2100	=		†
(125)	Stock Reduction - Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (19)		X	0.2100	=		†
(126)	Stock Increase - Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (20)		X	0.2100	=		
	Schedule BA Unaffiliated Common Stock/ Equity Interests and Affiliated Non-Insurance Stock (C1-cs), excluding Residual							
(127)	Tranches or Interests	LR008 Other Long-Term Assets Column (5) Line (49) - Line (45)		X	0.2100	=		
(128)	Total Residual Tranches or Interests	LR008 Other Long-Term Assets Column (5) Line (45)		X	0.2100	=		
(129)	Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)		X	0.2100	=		
(130)	NAIC 01 Working Capital Finance Notes	LR008 Other Long-Term Assets Column (5) Line (52.1)		X	0.1575	=		
(131)	NAIC 02 Working Capital Finance Notes	LR008 Other Long-Term Assets Column (5) Line (52.2)		X	0.1575	=		
(132)	Holding Company in Excess of Indirect Subs	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (7)		X	0.2100	=		
(133)	Affiliated Non-Insurers	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (19) + (20) + (21)		X	0.2100	=		
(134)	Total for C-1cs Assets	Lines (123)-(124)-(125)+(126)+(127)+(128)+(129)+(130)+(131)+(132)+(133)						
	Insurance Risk							
(135)	Disability Income Premium	LR019 Health Premiums Column (2) Lines **(34)**		X	0.2100	=		

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CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

		Source	(1) RBC Amount		Tax Factor		(2) RBC Tax Effect
(136)	Long-Term Care	LR019 Health Premiums Column (2) Line (35) + LR023 Long-Term Care Column (4) Line (7)		X	0.2100	=	
(137)	Individual & Industrial Life Insurance C-2 Risk	LR025 Life Insurance Column (2) Line (5)		X	0.2100	=	
(138)	Group & Credit Life Insurance C-2 Risk	LR025 Life Insurance Column (2) Line (12)		X	0.2100	=	
(138b)	Longevity C-2 Risk	LR025-A Longevity Risk Column (2) Line (5)		X	0.2100	=	
(139)	Disability and Long-Term Care Health Claim Reserves	LR024 Health Claim Reserves Column (4) Line (9) + Line (15)		X	0.2100	=	
(140)	Premium Stabilization Credit	LR026 Premium Stabilization Reserves Column (2) Line (10)		X	0.0000	=	
(141)	Total C-2 Risk	L(135) + L(136) + L(139) + L(140) + Greatest of [Guardrail Factor * (L(137)+L(138)), Guardrail Factor * L(138b), Square Root of [(L(137) + L(138))2 + L(138b)2 + 2 * (Correlation Factor) * (L(137) + L(138)) * L(138b)]]					
(142)	Interest Rate Risk	LR027 Interest Rate Risk Column (3) Line (36)		X	0.2100	=	
(143)	Health Credit Risk	LR028 Health Credit Risk Column (2) Line (7)		X	0.0000	=	
(144)	Market Risk	LR027 Interest Rate Risk Column (3) Line (37)		X	0.2100	=	
(145)	Business Risk	LR029 Business Risk Column (2) Line (40)		X	0.2100	=	
(146)	Health Administrative Expenses	LR029 Business Risk Column (2) Line (57)		X	0.0000	=	
(147)	Total Tax Effect	Lines (110) + (122) + (134) + (141) + (142) + (143) + (144) + (145) + (146)					

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HEALTH PREMIUMS PR019

			Annual Statement Source	(1) Statement Value	Factor		(2) RBC Requirement
	Medical Insurance Premium - Individual						
(1)	Comprehensive (Medical and Hospital)		Earned Premium (U&I Part 1, Column 4 Line 13.1)	0	†		XXX
(2)	Title XVIII Medicare		Earned Premium (U&I Part 1, Column 4 Line 15.6 in part)	0	†		XXX
(3)	Title XIX Medicaid		Earned Premium (U&I Part 1, Column 4 Line 15.5 in part)	0	†		XXX
(4)	Medicare Supplement		Earned Premium (U&I Part 1, Column 4 Line 15.4 in part)	0	†		XXX
(5)	Vision Only		Earned Premium (U&I Part 1, Column 4 Line 15.1 in part)	0	†		XXX
(6)	Dental Only		Earned Premium (U&I Part 1, Column 4 Line 15.2 in part)	0	†		XXX
(7.1)	Stand-Alone Medicare Part D Coverage		Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	†		XXX
(7.2)	Supplemental Benefits within Stand-Alone Part D Coverage (Claims Incurred)		Company Records	0	0.500		0
(7.3)	Medicaid Pass-Through Payments Reported as Premium		Company Records	0	0.020		0
(8)	Hospital Indemnity and Specified Disease		Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	0.035	*	0
(9)	AD&D (Maximum Retained Risk Per Life	0)	Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	‡		0
(10)	Other Accident		Earned Premium (U&I Part 1, Column 4 Line 15 in part)	0	0.050		0
	Medical Insurance Premium - Group and Credit						
(11)	Comprehensive (Medical and Hospital)		Earned Premium (U&I Part 1, Column 4 Line 13.2)	0	†		XXX
(12)	Title XVIII Medicare		Earned Premium (U&I Part 1, Column 4 Line 15.6 in part)	0	†		XXX
(13)	Title XIX Medicaid		Earned Premium (U&I Part 1, Column 4 Line 15.5 in part)	0	†		XXX
(14)	Vision Only		Earned Premium (U&I Part 1, Column 4 Line 15.1 in part)	0	†		XXX
(15)	Dental Only		Earned Premium (U&I Part 1, Column 4 Line 15.2 in part)	0	†		XXX
(16)	Stop Loss and Minimum Premium		Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	¥		0
(17)	Medicare Supplement		Earned Premium (U&I Part 1, Column 4 Line 15.4 in part)	0	†		XXX
(18.1)	Stand-Alone Medicare Part D Coverage (see instructions for limits)		Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	†		XXX
(18.2)	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)		Company Records	0	0.500		0
(18.3)	Medicaid Pass-Through Payments Reported as Premium		Company Records	0	0.020		0
(19)	Hospital Indemnity and Specified Disease		Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	0.035	*	0
(20)	AD&D (Maximum Retained Risk Per Life	0)	Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	‡		0
(21)	Other Accident		Earned Premium (U&I Part 1, Column 4 Line 15 in Part)	0	0.050		0
(22)	Federal Employee Health Benefit Plan		Earned Premium (U&I Part 1, Column 4 Line 15.8)	0	0.000		0
	Disability Income Premium						
(23)	Noncancellable Disability Income - Individual Morbidity		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		0
(24)	Other Disability Income - Individual Morbidity		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		0
(25)	Disability Income - Credit Monthly Balance Plans		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		
(26)	Disability Income - Group Long-Term		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		0
(27)	Disability Income - Credit Single Premium with Additional Reserve		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		0
(28)	Disability Income - Credit Single Premium without Additional Reserve		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		0
(29)	Disability Income - Group Short-Term		Earned Premium (U&I Part 1, Column 4 Line 15.3 in part)	0	‡		0
(30)	Total Disability Income		Earned Premium (U&I Part 1, Column 4 Line 15.3)	0			
	Long-Term Care						
(31)	Noncancellable Long-Term Care Premium - Rate Risk**		Earned Premium (U&I Part 1, Column 4 Line 15.7 in part)	0	0.100		0
(32)	Other Long-Term Care Premium ‡ ‡		Earned Premium (U&I Part 1, Column 4 Line 15.7 in part)	0	0.000		0 ‡ ‡
(33)	Total Long-Term Care		Earned Premium (U&I Part 1, Column 4 Line 15.7)	0			
	Health Premium with Limited Underwriting Risk						
(34)	ASC Business with Premium Revenue		Earned Premium (U&I Part 1, Column 4 Line 15.9 in part)	0	0.000		0
	Other Health						
(35)	Other Health		Earned Premium (U&I Part 1, Column 4 Line 14 and 15.9 in part)	0	0.120		0
(36)	Total Earned Premiums		Sum of Lines (1) through (22), Line (30), and Lines (33) through (35) minus Lines (7.3) and (18.3)	0			0
	C(1), L(36) should equal U&I Part 1 Column 4 Lines 13.1 through 15.9						
(37)	Additional Reserves for Credit Disability Plans		Company records	0	§		
(38)	Additional Reserves for Credit Disability Plans, prior year		Company records	0	§		

† The premium amounts in these lines are transferred to PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement, Dental & Vision and Stand-Alone Medicare Part D Coverage Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete PR021 Underwriting Risk – Managed Care Credit. In which case, the company will also need to complete PR013 Health Credit Risk in the formula. If there are amounts in any of lines (1) through (6), (11) through (15), and (17) on page PR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of PR023.

‡ The two tiered calculation is illustrated in the risk-based capital instructions for PR019 Health Premiums.

‡ ‡ The balance of the RBC requirement for Long Term Care - Morbidity Risk is calculated on Page PR023. The premium is shown to allow totals to check to U&I Part 1.

* If there is premium included on either or both of these lines, the RBC value in Column (2) will include 3.5% of such premium and $50,000 (included in the line with the larger premium).

** The factor applies to all Noncancellable premium.

§ These amounts are used to adjust the premium base for single premium credit disability plans that carry additional tabular reserves.

¥ A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (16) and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

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

UNDERWRITING RISK - PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION PR020

(Experience Fluctuation Risk in Life RBC Formula)

		(1) Comprehensive Medical Individual	(2) Comprehensive Medical Group	(3) Title XVIII-Medicare	(4) Title XIX-Medicaid	(5) Medicare Supplement	(6) Vision Only	(7) Dental Only	(8) Stand-Alone Medicare Part D Coverage	(9) TOTAL
(1.1)	Individual Premium	0	0	0	0	0	0	0	0	0
(1.2)	Group Premium	0	0	0	0	0	0	0	0	0
(1.3)	Total Premium	0	0	0	0	0	0	0	0	0
(2)	Other Health Risk Revenue†	0	0	0	0	XXX	0	0	0	0
(3)	Medicaid Pass-Through Payments Reported as Premium	XXX	XXX	XXX	0	XXX	XXX	XXX	XXX	0
(4)	Underwriting Risk Revenue = Lines (1.3) + (2) - (3)	0	0	0	0	0	0	0	0	0
(5)	Net Incurred Claims	0	0	0	0	0	0	0	0	0
(6)	Medicaid Pass-Through Payments Reported as Claims	XXX	XXX	XXX	0	XXX	XXX	XXX	XXX	0
(7)	Fee-for-Service Offset†	0	0	0	0	XXX	0	0	0	0
(8)	Underwriting Risk Incurred Claims = Lines (5) – (6) – (7)	0	0	0	0	0	0	0	0	0
(9)	Underwriting Risk Claim Ratio (8)/(4)	0	0	0	0	0	0	0	0	XXX
(10)	Underwriting Risk Factor for Initial Amounts Of Premium‡	0.1440	0.1440	0.1440	0.1440	0.0987	0.1153	0.1153	0.251	XXX
(11)	Underwriting Risk Factor for Excess of Initial Amount‡	0.0844	0.0844	0.0844	0.0844	0.0609	0.0716	0.0716	0.151	XXX
(12)	Investment Income Adjustment Factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	XXX	XXX
(13)	Composite Underwriting Risk Factor	A1	A1	A1	A1	A2	A2	A2	A3	XXX
(14)	Base Underwriting Risk RBC = Line (4) x Line (9) x Line (13)	0	0	0	0	0	0	0	0	XXX
(15)	Managed Care Discount Factor = PR021 Line (12)	0	0	0	0	0	0	0	0	XXX
(16)	Base RBC After Managed Care Discount = Line (14) x Line (15)	0	0	0	0	0	0	0	0	0
(17)	Alternate Risk Charge	500,000	500,000	500,000	500,000	50,000	50,000	50,000	150,000	XXX
(18)	Net Alternate Risk Charge	B0	B0	B0	B0	B1	B2	B2	B3	0
(19)	Net Underwriting Risk RBC (Maximum of Line (16) or Line (18))	0	0	0	0	0	0	0	0	0

† Source is company records unless already included in premiums.

Initial Premium Amount‡							
Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement	Vision	Dental	Stand-Alone Medicare Part D Coverage
$25,000,000	$25,000,000	$25,000,000	$25,000,000	$3,000,000	$3,000,000	$3,000,000	$25,000,000

~~§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).~~

~~* The Line (17) Alternate Risk Charge is calculated as follows:~~

~~£ Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.~~

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

PR020 Formulas

Cell Label	Formula
A1	=Line 12 x {Min[Line (4) x Line (10), 25,000,000 x Line (10)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
A2	=Line 12 x {Min[Line (4) x Line (10), 3,000,000 x Line (10)] + Max[0, (Line (4) - 3,000,000) x Line (11)] } / Line (4)
A3	={Min[Line (4) x Line (10), 25,000,000 x Line (10)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
B0	=If[OR[Line (4) > 0, Line (8) > 0], 500,000, 0]
B1	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)], 0]
B2	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)], 0]
B3	=If[OR[Line (4) > 0, Line (8) > 0], Max[0, 150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(

UNDERWRITING RISK - OTHER AND TOTAL NET HEALTH PREMIUM RBC PR022

			(1) Amount	Factor	(2) RBC Requirement
	Rate Guarantees & Federal Employees Health Benefits	Data Source			
(1)	Business with Rate Guarantees Between 15-36 Months	Company Records	0	0.024	0
(2)	Business with Rate Guarantees Over 36 Months	Company Records	0	0.064	0
(3)	Federal Employees Health Benefit Program (FEHBP) Claims Incurred	Company Records	0	0.020	0
(4)	Total, Rate Guarantees & Federal Employees Health Benefits	L(1) + L(2) + L(3)	0		0
	Administrative Expenses for Certain A&H Coverages				
(5)	Total Accident and Health Premiums	PR019 Health Premiums Column (1) Line (**36**)	0		
(6)	Accident and Health Premiums from Underwriting Risk	PR020 Underwriting Risk Column (**9**) Line (**1.3**)	0		
(7)	Accident and Health Premiums Factor	L(6)/L(5)	0.000		
(8)	Administrative Expenses for Health Insurance	Company Records	0		
(9)	Less Administrative Expenses for Administrative Service Contracts (ASC) included in Line (8)	Company Records	0		
(10)	Less Administrative Expenses for Administrative Services Only (ASO) Business included in Line (8)	Company Records	0		
(11)	Less Administrative Expenses for Commissions and Premium Taxes	Company Records	0		
(12)	Net Administrative Expenses	L(8) - L(9) - L(10) - L(11)	0		
(13)	Composite Health Administrative Expense Risk Factor	(7% of L(6) up to $25 million + 4% of excess)/L(6)	0.000		
(14)	Administrative Expense Component for Health	L(12) x L(7) x L(13)			0
	Health ASO/ASC				
(15)	Administrative Expenses for ASC Business	Company Records*	0	0.020	0
(16)	Administrative Expenses for ASO Business	Company Records*	0	0.020	0
(17)	Total Health ASO/ASC	L(15) + L(16)	0		0
(18)	Total Underwriting Risk - Other	L(4) + L(14) + L(17)			0
	Total Net Health Premium RBC				
(19)	Total Health Premium RBC	L(18) + PR019 C(2) L(**36**) + PR020 C(**9**) L(**19**)			
(20)	Premium Concentration Factor	PR018 C(20) L(14)			1.000
(21)	Total Net Health Premium RBC	L(19) x L(20)			0

* Line (15) should be greater than or equal to Line (9). Line (16) should be greater than or equal to Line (10).

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

PREMIUM STABILIZATION RESERVES PR025

		Data Source	(1) Statement Value	Factor	(2) RBC Requirement
	Group & Credit Health Premium Stabilization Reserves Reported				
(1)	Stabilization Reserves and Experience Rating Refunds	Company Records	0	0.500	0
(2)	Provision for Experience Rating Refunds	Company Records	0	0.500	0
(3)	Reserve for Group Rate Credits	Company Records	0	0.500	0
(4)	Reserve for Credit Rate Credits	Company Records	0	0.500	0
(5)	Premium Stabilization Reserves	Company Records	0	0.500	0
(6)	Total of Preliminary Premium Stabilization Reserve Credit	Sum of Lines (1) through (5)	0		0
	Group & Credit Health Risk-Based Capital				
(7)	Maximum Risk-Based Capital	PR024 Health Claim Reserves Column (2) Line (2) + PR019 Health Premiums Column (2) Lines **(16), (19), (20), (21), (25), (26), (27), (28) and (29)** + [PR020 Underwriting Risk- Premiums Risk **Column (9) Line (19) - Column (8) Line (19)** x **Column (9) Line (1.2) / Column (9) Line (1.3)**]	0		
(8)	Final Premium Stabilization Reserve Credit	Column (2) Line (6), but not more than Column (1) Line (7)	0	-1.000	0

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

December 22, 2025

Chairman Steve Drutz
c/o Derek Noe, Health RBC Analyst
NAIC Health Risk-Based Capital Working Group
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

RE: Managed Care Credit Concept Draft exposure

Dear Chairman Drutz and Working Group members,

The provided comments concentrate on the proposed reporting format and the proposed instructions for the Managed Care Credit Concept Draft. They do not cover the overall concept of the proposal.

Exhibit 7
Table 1 indicates "direct" payments. Should that include "assumed" business, if there is any? Table 2 specifically indicates ceded reinsurance, with Table 3 being net. But what if the reporting entity has "assumed" business?

The exposure does not indicate the renaming of Exhibit 7 – Part 1. Therefore, the new additions should be entitled Exhibit 7 – Part 1A, not Part 1B. In addition, in order to conform to the usual format used for statement reporting, identifiers labeled as "tables" should be renamed in the following manner.

Exhibit 7 – Part 1A- Section 1 – Summary of Transactions with Providers – Direct Medical Payments
Exhibit 7 – Part 1A- Section 2 – Summary of Transactions with Providers – Reinsurance Ceded Medical Payments
Exhibit 7 – Part 1A- Section 3 – Summary of Transactions with Providers – Net Medical Payments

Within statement reporting, instructions usually do not indicate if reporting is used for the RBC calculation or not. Therefore, suggest removing the following statement from the instructions for Exhibit 7 – Part 1B.

EXHIBIT 7 – PART 1A~~B~~ – SUMMARY OF TRANSACTIONS WITH PROVIDERS

~~Please note that Exhibit 7- Part 1B is for information-only and will not impact RBC calculations.~~

Based on the above mentioned renaming, the following rewrite within the instructions is suggested.

This schedule requires disclosure of claim payments by type of managed care arrangement.
~~Table 2 – Net Reinsurance Amount~~
~~Amount of payment ceded to reinsurance~~
~~Table 3 – Medical Expense Payment (Net of Reinsurance)~~
~~Table 1 - 2~~
Section 1 discloses direct medical expenses paid.
Section 2 discloses ceded reinsurance payment.
Section 3 discloses the net amount of medical expense payments and is calculated, on a column per column basis, as Section 1 minus Section 2.

Also suggest adding an instructional line prior to the line definitions that states:
Except as noted, instructions for the various reporting lines are defined in the instructions for Exhibit 7 – Part 1.

An instruction for the columnar lines of business should be included. For example
Columnar lines of business are defined in the instructions for the Analysis of Operations By Line of Business (ANAOPS).

Please note, however, the correct reference may not be the ANAOPs. The lines of business are generally defined in the statement instructions either for a specific schedule, like the ANAOPS or in the Appendix. The problem here is if the reader is referred to the definitions provided for the ANAOPS, not all of the definitions match. For example, on the ANAOPS "Other Health" includes policies providing stand alone Medicare Part D. On the proposed Exhibit 7 – Part 1A, stand-alone Medicare Part D is reported separately and not part of "Other Health." A referral to the Appendix of the statement instructions also would be incomplete, as not all of the referenced lines of business are included in the Appendix.

Since the proposed reporting sections are labeled as "payments" it could be assumed that cash amounts are to be reported. Line 7 seems to comply with that concept. However, Line 7.1, "Bonus Payment Exposure," appears to ask for an incurred number or maybe an outstanding liability number. The directions say this reporting applies to the prior year. Therefore, it seems the description of Line7.1 should be "Bonus Payment Expense, prior year." At the same time, the instructions need to provide more reporting detail. For example, are these payments that were made in the current year, but were incurred and unpaid at the end of the prior year (and would be included in Line 7)? Or does this line ask for the total amount of bonus payments that were made during the prior year (maybe as a comparison to the reported amount in Line 7 for the current year)?

A similar problem arises with Line 7.2 which should probably also have a new line description of “Bonus Payments Made, prior year” and also have more specific instructional details.

For The same types of problems exist for **Lines 8.1, 8.2, 10.1, 10.2, and 10.3**. All have a mixture of what appears to be payment amounts (cash) and incurred or liability amounts., as well as some of them referring to prior year amounts.

Line 9 instructions could benefit from examples and/or more clarity. What would be the difference between amounts reported as “bundled” vs. “fee-for-service” or “contractual fee payments?”

Line 14 needs an explicit provided calculation. Is the calculation the sum of Lines 5+6+7+8+9+10+11+12+13? Or are lines 7.1, 7.2, 8.1, 8.2, 10.1, 10.2 and 10.3 also included in the calculation?

Sincerely,

Connie Jasper Woodroof

Connie Jasper Woodroof
CJW Associates
connie.cjwassociates@gmail.com

UNITEDHEALTH GROUP

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

January 20, 2026

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 Derek Noe.

Re: Managed Care Credit Concept Draft.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group with regard to the "Managed Care Credit Concept Draft" exposed for comment by the Health Risk-Based Capital (E) Working Group ("Working Group") on November 6, 2025. In this letter, we will address several areas of concern: reinsurance; definitional issues regarding the managed care payment categories; issues specific to bonus and risk-sharing arrangements; and additional points for clarification.

Reinsurance.

The proposed Exhibit 7 Part 1B comprises three tables. Table 1 is for direct business; Table 2 is for reinsurance ceded; and Table 3 is labeled "Net Medical Expense Payment."

There may be difficulties in completing Table 2. For reinsurance ceded on a pure quota share basis, with no deductibles or caps, it may be relatively easy to categorize ceded claims by payment category — although even then there may be issues, depending on how easy it is to identify ceded business in the system that is producing the claim splits. However, when the reinsurance includes any kind of non-proportional elements, it may be difficult to determine exactly which payment types were actually reimbursed.

Furthermore, as the goal of Table 2 presumably is to determine how reinsurance impacts claim variability among the different payment types, the data provided may not be genuinely suitable for that purpose. Some of the difficulties in obtaining accurate data were noted in the preceding

paragraph. Additionally, the impact may differ by reinsurance type: quota share will not impact overall variability, whereas excess-loss reinsurance is likely to have a differing impact by payment type. Table 2 does not segregate types of reinsurance, and given the many possible variations in reinsurance agreements, doing so in a useful fashion would probably not be feasible.

We also note that Exhibit 7 Part 1B does not address reinsurance assumed. We do not recommend adding a table for reinsurance assumed; such a table would be subject to all of the shortcomings already noted for reinsurance ceded, with the added complication of obtaining timely data from the ceding company. However, the Managed Care Credit will presumably be applied to assumed claims, creating a disjoint.

The original (and still current) Managed Care Credit is based on direct business only. We believe that this approach reflects the issues just described with regard to reflecting reinsurance in a useful manner, and we recommend that this approach be continued in the future. While that may reduce the precision of the credit, for the reasons previously cited we do not believe that greater precision is likely to be achieved in practice by trying to model the impact of reinsurance. Therefore, we recommend that Tables 2 and 3 be eliminated from the proposed exhibit.

Managed care payment categories.

Clearer definitions are needed for the various categories of managed care payment categories. There is some additional explanation in the instructions for the existing Exhibit 7 Part 1, and there are also descriptions in the Health Risk-Based Capital instructions which presumably apply as well. However, since the categorization for the proposed Exhibit 7 Part 1B does not correspond one-to-one with the existing categorization, the existing definitions cannot be relied on with certainty. Therefore, detailed definitions should be provided, with examples to help clarify exactly what types of arrangements are being described.

Bonus and risk-sharing arrangements.

Payment categories 7 and 8 in the proposed Exhibit 7 Part 1B are "bonus/withhold arrangements" (category 7 being for those arrangements that would otherwise qualify as "fee-for-service," and category 8 being for arrangements that would otherwise qualify as "contractual fee payments"). Payment category 10 is for "upside and downside risk sharing."

"Upside and downside risk sharing" is described as "Payments to contracting providers or intermediaries that are subject to shared savings relative to a target with both an up and downside risk component" [emphasis added]. Presumably, arrangements that are upside-only are considered to be bonus arrangements and are included in category 7 or 8, but it would be helpful to have that explicitly stated. The treatment of downside-only arrangements, which are uncommon but do exist, is less obvious. Should they be included with other risk-sharing arrangements, in which case the description needs to be revised to reflect that? Or are they considered to be bonus arrangements, with the "bonus" being the difference between the baseline payment and the payment level assuming the full downside adjustment?

We note that not all bonus and risk-sharing arrangements operate on a calendar-year basis. While it would be possible to assign some portion of the bonus or risk-sharing payment to each partial calendar year covered by a particular arrangement period, the method for doing so might vary among reporting entities, resulting in a lack of consistency across the Exhibit 7 Part 1B filings. We recommend including in a given reporting year those payments arising from arrangement periods that ended during that reporting year.

The instructions for lines 7.1, 7.2, 8.1, 8.2, 8.3, 10.1, 10.2, and 10.3 all refer to "prior year." We understand this to mean the year prior to the reporting year, rather than the year in which the statement is filed; for example, with respect to the 2026 Annual Statement, "prior year" would be 2025 (the year before the reporting period) rather than 2026 (the year before the Annual Statement will be filed). It might be helpful to clarify that by an example in the instructions.

Additional points for clarification.

Presumably, the intention is that the sum across all columns of Exhibit 7 Part 1B, Table 1, line 15 will be equal to Exhibit 7 Part 1, column 1, line 13. If that is the case, it would be helpful to have that explicitly stated in the instructions. If that is not the case, we would like an explanation of why there would be a difference; and that explanation should be included in the instructions, in order to minimize confusion.

* * * * *

Thank you for the opportunity to provide these comments. We would be happy to discuss these comments with you and the Working Group.

Sincerely,

James R. Braue
Vice President, Actuarial Services
UnitedHealth Group

cc: Derek Noe, NAIC
Alena Yankouskaya, UnitedHealth Group
Mollie Zito, UnitedHealth Group

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Katie Dzurec, American Academy of Actuaries
Steve Guzski, American Academy of Actuaries
Derek Skoog, American Academy of Actuaries
Julian Levin, American Academy of Actuaries

FROM: Steve Drutz, Chair, Health Risk-Based Capital (E) Working Group
Danielle Smith, Vice Chair, Health Risk-Based Capital (E) Working Group

DATE: February XX, 2026

RE: Request for Academy Responses to H-2 Project Comments

The Health Risk-Based Capital (E) Working group received the *H-2 Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula Report* from the American Academy of Actuaries (Academy) at its April 30, 2025, call. The report included six sets of factors at two risk percentiles and three time horizons. The Working Group would like the Academy to provide its thoughts on a possible three-year phase-in approach, in which the final factors and/or premium tier would be approached over three years. We note that the need for a phased-in approach was contemplated in the report (page 27, last sentence). Does the Academy foresee any issues with this approach?

The Working Group also received a comment from interested parties asking the Academy to review factors for Medicaid and determine an appropriate tier to align with the other factors presented in the report. The report notes that the reason the Medicaid factors did not include a tiered approach is for credibility purposes (page 26, last paragraph). Can you provide an example of the Tier 1 and Tier 2 risk factors that came from the data, ignoring the credibility issues? Was there a specific cut-off point between Tiers 1 and 2 that made sense based on the data (again, ignoring the credibility issues)?

Commenters also had questions about the data development that the Working Group would like the Academy to address. Paraphrased below are the questions with our input. Please refer to the attached comment letters for details and context.

- How were the premium tiers chosen for the lines of business? We note that the adjustment of tier cut-points from $3 million and $25 million to $10 million and $100 million is intended to capture market dynamics that influence risk (page 27, third paragraph), but were there other logical cut-points apparent based on a noticeable change in the volatility of the results between larger and smaller companies?

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- Reinsurance was allocated between individual and group lines based on premium share. Is there a reason for the allocation instead of using the reported values? (Our understanding is that reinsurance recoveries information was only available for the two lines of business combined.)
- Was any analysis done removing the Affordable Care Act (ACA) implementation and/or COVID events? If so, what were the results?
- What percentage of companies were excluded as outliers?

The Working Group received comments from interested parties regarding the implementation of the Alternate Risk Charge in Proposal 2025-15-CA. Can the Academy clarify by what method the Alternate Risk Charge was proposed to be implemented in the report, and if the implementation in Proposal 2025-15-CA meets that implementation recommendation (page 9, last paragraph)?

The Working Group also received comments from interested parties on the exposure of Exhibit 7, Part 1B, and would like the Academy's help addressing them. Paraphrased below are the questions. Please refer to the attached comment letters for details and context.

- Was "Assumed Reinsurance" left out of the exhibit purposefully, and does the Academy believe the exclusion of the Assumed business affects future analysis?
- Can the Academy refine the line descriptions to be more specific about the types of contracts that would be reported on those lines? Would the Academy need help from interested parties during the refinement process?
- Can the Academy clarify if the values are to be reported on a cash basis or an accrual basis?
- Some lines refer to the prior year. Can you clarify if that is the filing year or the year before the filing year?
- Can the Academy create an illustrative example for how Exhibit 7, Part 1B, would be filled out?

Thank you for taking the time to answer our questions. Please reply with written answers by March 11, 2026. Please contact the Health Risk-Based Capital (E) Working Group's NAIC committee support with any questions.

Cc: Derek Noe, Maggie Chang, Eva Yeung, Kazeem Okosum

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