NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 4/22/21

Virtual Meeting
CAPITAL ADEQUACY (E) TASK FORCE
Thursday April 29, 2021
2:00 – 3:00 p.m. ET / 1:00 – 2:00 p.m. CT / 12:00 p.m. – 1:00 p.m. MT / 11:00 a.m. – 12:00 p.m. PT

ROLL CALL

Judith L. French, Chair	Ohio	Sharon P. Clark	Kentucky
Doug Slape, Vice Chair	Texas	Grace Arnold	Minnesota
Jim L. Ridling	Alabama	Chlora Lindley-Myers	Missouri
Lori K. Wing-Heier	Alaska	Bruce R. Ramge	Nebraska
Ricardo Lara	California	Marlene Caride	New Jersey
Andrew N. Mais	Connecticut	Mike Causey	North Carolina
Karima M. Woods	District of Columbia	Glen Mulready	Oklahoma
David Altmaier	Florida	Raymond G. Farmer	South Carolina
Dana Popish Severinghaus	Illinois	Mike Kreidler	Washington
Doug Ommen	Iowa	Mark Afable	Wisconsin
Vicki Schmidt	Kansas		

NAIC Support Staff: Jane Barr

AGENDA

1. Consider Exposure of Proposal 2021-07-CA (Receivables for Securities) —*Tom Botsko (OH)* — Attachment A

2. Consider Exposure of Proposal 2021-04-CA (Investment Income in Health Underwriting Factors)—*Steve Drutz (WA)* — Attachment B

3. Consider Adoption of Proposal 2021-01-L (Real Estate Structure) —*Philip Barlow (DC)* — Attachment C

4. Consider Adoption of Proposal 2021-02-CA (Managed Care Credit Incentives)—*Steve Drutz (WA)* — Attachment D

5. Consider Adoption of Proposal 2021-03-P (Credit Risk Instruction Modification) —*Tom Botsko (OH)* — Attachment E

6. Consider Adoption of its Working Agenda—*Tom Botsko (OH)* — Attachment F

7. Discuss Any Other Matters Brought Before the Task Force

8. Adjournment

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Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE:	**4/29/2021**
CONTACT PERSON:	**Jane Barr**
TELEPHONE:	
EMAIL ADDRESS:	
ON BEHALF OF:	**Capital Adequacy Task Force**
NAME:	**Tom Botsko**
TITLE:	**Chair**
AFFILIATION:	**Ohio Department of Insurance**
ADDRESS:	**50 West Town Street, Suite 300**
	Columbus, OH 43215

FOR NAIC USE ONLY

Agenda Item # 2021-07-CA

Year 2021

DISPOSITION

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

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

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

DESCRIPTION OF CHANGE(S)

Update the RBC factors for Receivables for Securities.

REASON OR JUSTIFICATION FOR CHANGE **

Based on a weighted average calculation of bonds, common, preferred and hybrid stock investments, the receivable for securities factors were adjusted for all RBC forecasting blanks.

Additional Staff Comments:

**** This section must be completed on all forms.** **Revised 2-2019**

	Proposed 2021	2018	2016	2014
Life	**0.015**	0.014	0.014	0.014
Health	**0.024**	0.025	0.024	0.024
P/C	**0.020**	0.025	0.023	0.024

Proposed 2021 Life RBC Factor for Receivables for Securities

	(1)	(2)	-3.0000	(4)	(5)	(6)
	Statement Value	Allocation % by Class Type	RBC Factors by Class Type	Weighted Avg RBC Factor by Class type (2)x(3)	Allocation % by Asset type (1)/Total (1)	Weighted Avg RBC by Asset type (4)x(5)
Bonds and Hybrids						
Exempt Obligations	203,681,899,268	5.93%	0.0000	0.000		
NAIC 1	1,755,070,452,018	51.06%	0.0039	0.002		
NAIC 2	1,266,205,845,000	36.84%	0.0126	0.005		
NAIC 3	138,002,043,541	4.02%	0.0446	0.002		
NAIC 4	54,220,375,402	1.58%	0.0970	0.002		
NAIC 5	17,360,937,037	0.51%	0.2231	0.001		
NAIC 6	2,419,944,866	0.07%	0.3000	0.000		
Subtotal	**3,436,961,497,132**	**100.00%**		**0.011**	**98.32%**	**0.011**
Preferred stock						
NAIC 1	3,236,974,611	21.34%	0.0040	0.001		
NAIC 2	8,058,180,267	53.14%	0.0130	0.007		
NAIC 3	1,626,957,797	10.73%	0.0460	0.005		
NAIC 4	954,076,003	6.29%	0.1000	0.006		
NAIC 5	825,983,462	5.45%	0.2300	0.013		
NAIC 6	462,924,058	3.05%	0.3000	0.009		
Subtotal	**15,165,096,198**	**100.00%**		**0.041**	**0.43%**	**0.000**
Common stock (subtotal)	**43,472,175,917**	**100.00%**	**0.3000**	**0.300**	**1.24%**	**0.004**
Total	**3,495,598,769,247**				**100.00%**	**0.015**

Proposed 2021 P&C RBC Factor for Receivables for Securities

	(1) Statement Value	(2) Allocation % by Class Type	(3) RBC Factors by Class Type	(4) Weighted Avg RBC Factor by Class type (2)x(3)	(5) Allocation % by Asset type (1)/Total (1)	(6) Weighted Avg RBC by Asset type (4)x(5)
Bonds						
Exempt Obligations	198,077,770,204	14.73%	0.000	0.000		
NAIC 1	892,606,935,183	66.40%	0.003	0.002		
NAIC 2	196,155,056,615	14.59%	0.010	0.001		
NAIC 3	29,627,422,364	2.20%	0.020	0.000		
NAIC 4	22,407,220,194	1.67%	0.045	0.001		
NAIC 5	4,921,385,393	0.37%	0.100	0.000		
NAIC 6	575,257,936	0.04%	0.300	0.000		
Subtotal	**1,344,371,047,889**	**100.00%**		**0.005**	**88.49%**	**0.005**
Preferred stock						
NAIC 1	268,672,231	2.06%	0.003	0.000		
NAIC 2	5,385,911,971	41.35%	0.010	0.004		
NAIC 3	1,610,172,447	12.36%	0.020	0.002		
NAIC 4	5,454,937,067	41.88%	0.045	0.019		
NAIC 5	167,040,637	1.28%	0.100	0.001		
NAIC 6	137,185,850	1.05%	0.300	0.003		
Subtotal	**13,023,920,203**	**100.00%**		**0.030**	**0.86%**	**0.000**
Hybrid Securities						
NAIC 1	195,915,508	5.41%	0.003	0.000		
NAIC 2	2,602,668,840	71.83%	0.010	0.007		
NAIC 3	796,155,236	21.97%	0.020	0.004		
NAIC 4	28,186,843	0.78%	0.045	0.000		
NAIC 5	629,783	0.02%	0.100	0.000		
NAIC 6	16,321	0.00%	0.300	0.000		
Subtotal	**3,623,572,531**	**100.00%**		**0.012**	**0.24%**	**0.000**
Common stock (subtotal)	**158,185,376,976**	**100.00%**	**0.150**	**0.150**	**10.41%**	**0.016**
Total	**1,519,203,917,599**				**100.00%**	**0.020**

Proposed 2021 Health RBC Factor for Receivables for Securities

	(1) Statement Value	(2) Allocation % by Class Type	(3) RBC Factors by Class Type	(4) Weighted Avg RBC Factor by Class type (2)x(3)	(5) Allocation % by Asset type (1)/Total (1)	(6) Weighted Avg RBC by Asset type (4)x(5)
Bonds						
Exempt Obligations	26,978,694,441	16.82%	0.000	0.000		
NAIC 1	92,173,162,315	57.45%	0.003	0.002		
NAIC 2	31,516,321,303	19.64%	0.010	0.002		
NAIC 3	5,719,206,660	3.56%	0.020	0.001		
NAIC 4	3,540,212,585	2.21%	0.045	0.001		
NAIC 5	369,787,474	0.23%	0.100	0.000		
NAIC 6	134,137,224	0.08%	0.300	0.000		
Subtotal	**160,431,522,002**	**100.00%**		**0.006**	**86.84%**	**0.005**
Preferred stock						
NAIC 1	16,895,298	2.64%	0.003	0.000		
NAIC 2	409,146,343	63.86%	0.010	0.006		
NAIC 3	185,064,846	28.88%	0.020	0.006		
NAIC 4	768,429	0.12%	0.045	0.000		
NAIC 5	23,426,601	3.66%	0.100	0.004		
NAIC 6	5,410,086	0.84%	0.300	0.003		
Subtotal	**640,711,603**	**100.00%**		**0.018**	**0.35%**	**0.000**
Hybrid Securities						
NAIC 1	32,723,508	6.51%	0.003	0.000		
NAIC 2	356,672,701	70.96%	0.010	0.007		
NAIC 3	108,648,195	21.62%	0.020	0.004		
NAIC 4	972,052	0.19%	0.045	0.000		
NAIC 5	1,008,743	0.20%	0.100	0.000		
NAIC 6	2,600,202	0.52%	0.300	0.002		
Subtotal	**502,625,401**	**100.00%**		**0.013**	**0.27%**	**0.000**
Common stock (subtotal)	**23,167,522,031**	**100.00%**	**0.150**	**0.150**	**12.54%**	**0.019**
Total	**184,742,381,037**				**100.00%**	**0.024**

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Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE:	**3-17-21**
CONTACT PERSON:	**Crystal Brown**
TELEPHONE:	**816-783-8146**
EMAIL ADDRESS:	**cbrown@naic.org**
ON BEHALF OF:	**Health RBC (E) Working Group**
NAME:	**Steve Drutz**
TITLE:	**Chief Financial Analyst/Chair**
AFFILIATION:	**WA Office of Insurance Commissioner**
ADDRESS:	**PO Box 40255**
	Olympia, WA 98504-0255

FOR NAIC USE ONLY

Agenda Item # 2021-04-CA

Year 2021

DISPOSITION

[ ] ADOPTED _____
[ ] REJECTED _____
[ ] DEFERRED TO _____
[ ] REFERRED TO OTHER NAIC GROUP
[x] EXPOSED 4-16-21
[ ] OTHER (SPECIFY) _____

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

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

DESCRIPTION OF CHANGE(S)

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

REASON OR JUSTIFICATION FOR CHANGE **

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

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

Additional Staff Comments:

These changes will also need to be incorporated into the Life and P/C formula.
3-17-21 cgb The Working Group exposed the proposal for 30-days with comments due back on April 16, 2021.
4-23-21 cgb Two comment letters were received during the comment period from UHG and AHIP/BCBSA. The WG discussed the comments and agreed to refer the proposal to the Capital Adequacy (E) Task Force with the 0.5% investment yield for exposure for all lines of business.
04-27-21 cgb The American Academy of Actuaries provided an updated letter that included the factors to two-digit rounding for each tier. A copy of the letter is included in the proposal.

**** This section must be completed on all forms.** **Revised 2-2019**

HEALTH

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

DETAIL ELIMINATED TO CONSERVE SPACE

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

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

	$0 – $3 Million	$3 – $25 Million	Over $25 Million
Comprehensive Medical & Hospital	0.1493~~150~~	0.1493~~150~~	0.0893~~090~~
Medicare Supplement	0.1043~~5~~	0.0663~~7~~	0.0663~~67~~
Dental & Vision	0.1195~~20~~	0.0755~~6~~	0.0755~~6~~
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

DETAIL ELIMINATED TO CONSERVE SPACE

PROPERTY & CASUALTY

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

DETAIL ELIMINATED TO CONSERVE SPACE

Line (10) Underwriting Risk Factor
A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income yield of 0.5%.

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	$0 - $3 Million	$3-$25 Million	Over $25 Million
Comprehensive Medical	0.1493~~50~~	0.1493~~50~~	0.0893~~090~~
Medicare Supplement	0.1043~~5~~	0.0663~~7~~	0.0663~~7~~
Dental & Vision	0.1195~~20~~	0.0755~~6~~	0.~~076~~0755
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

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

DETAIL ELIMINATED TO CONSERVE SPACE

LIFE

Underwriting Risk – Experience Fluctuation Risk

LR020

DETAIL ELIMINATED TO CONSERVE SPACE

Line (10) Underwriting Risk Factor

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

	$0 - $3 Million	$3 - $25 Million	Over $25 Million
Comprehensive Medical	0.1493~~50~~	0.1493~~50~~	0.0893~~90~~
Medicare Supplement	0.1043~~5~~	0.0663~~7~~	0.0663~~7~~
Dental	0.1195~~20~~	0.0755~~6~~	0.0755~~76~~
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

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

DETAIL ELIMINATED TO CONSERVE SPACE

UNDERWRITING RISK

0.5% Investment Return

Experience Fluctuation Risk

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

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

ALTERNATE RISK CHARGE**

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

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013.

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

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

Property & Casualty and Life RBC Formulas

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

AMERICAN ACADEMY of ACTUARIES

Objective. Independent. Effective.™

April 27, 2021

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

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

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy)[1] Health Solvency Subcommittee, I am pleased to provide this response letter to the Health Risk-Based Capital (E) Working Group. This letter is in response to the request from the working group on April 23, 2021, to provide an additional digit within the subcommittee's summary of the Investment Income Adjusted Health H2 Experience Fluctuation Risk Factors. These factors are included within the table below.

Investment Income Adjusted Tiered RBC Factors

Assumed Investment Return	Comprehensive Medical (CM)	Medicare Supplement	Dental/Vision
	High Tier (i.e., less than $3M or less than $25M)		
0.0%	15.00%	10.50%	12.00%
0.1%	14.99%	10.49%	11.99%
0.5%	14.93%	10.43%	11.95%
1.0%	14.86%	10.36%	11.90%
1.5%	14.79%	10.29%	11.85%
2.0%	14.73%	10.22%	11.80%
3.0%	14.59%	10.08%	11.70%
	Low Tier		
0.0%	9.00%	6.70%	7.60%
0.1%	8.99%	6.69%	7.59%
0.5%	8.93%	6.63%	7.55%
1.0%	8.87%	6.56%	7.50%
1.5%	8.81%	6.50%	7.45%
2.0%	8.74%	6.43%	7.40%
3.0%	8.61%	6.30%	7.31%

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

Please note that the Comprehensive Medical (CM) RBC factors within the High Tier for the 1.0% and 1.5% investment returns is changed from 14.8% and 14.7% to 14.9% and 14.8% due to a typographic error in the prior draft of this table. Otherwise, the data is unchanged—only the rounding has been adjusted.

*****

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

Sincerely,

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

Cc: Crystal Brown: Senior Insurance Reporting Analyst

Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE: January 21, 2021	**FOR NAIC USE ONLY**
CONTACT PERSON: Steve Clayburn	Agenda Item # 2021-01-L
TELEPHONE: (202) 624-2197	Year 2021
EMAIL ADDRESS: steveclayburn@acli.com	**DISPOSITION**
ON BEHALF OF: American Council of Life Insurers (ACLI)	[ ] ADOPTED
NAME: Steve Clayburn	[ ] REJECTED
TITLE: Senior Actuary, Health Insurance & Reinsurance	[ ] DEFERRED TO
AFFILIATION: ACLI	[ ] REFERRED TO OTHER NAIC GROUP
ADDRESS:	[ ] EXPOSED
	[ ] OTHER (SPECIFY)

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

[ ] Health RBC Blanks [ ] Property/Casualty RBC Blanks [X] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions [ ] Property/Casualty RBC Instructions [X] Life and Fraternal RBC Blanks
[ ] OTHER _____

DESCRIPTION OF CHANGE(S)

To update the RBC calculation for Real Estate to reflect updated experience and analysis since RBC was first developed. The factors and instructions included are not final, with the exception of the structure which is included and presented in Figure 7, and will be addressed with a separate proposal.

REASON OR JUSTIFICATION FOR CHANGE **

When RBC was developed, there was limited experience on the default and loss for commercial real estate. Since then data sources have been compiled and tracked in the industry, and can now be accessed to provide more meaningful analysis and information for development of capital standards.

Additional Staff Comments:

**** This section must be completed on all forms.** **Revised 2-2019**

1. REAL ESTATE

LR007

Basis of Factors

~~Companies that have developed their own risk-based capital factors for real estate have used a range of factors from 5 percent to 20 percent. One study indicated real estate volatility is about 60 percent of common stock, suggesting a factor in the range of 18 percent. Assuming a full tax effect for losses, a pre-tax factor of 15 percent was chosen. Foreclosed real estate would carry a somewhat higher risk at 23 percent pre-tax. Schedule BA real estate also has a 23 percent factor pre-tax because of the additional risks inherent in owning real estate through a partnership. The pre-tax factors were developed by dividing the post-tax factor by 0.65 (0.65 is calculated by taking 1.0 less 0.35). The pre-tax factors are not changing for 2018 due to tax reform.~~ The base factor for equity real estate of **[10%]** was developed by adding a margin for conservatism to the results of an analysis of real estate performance over the period of 1978 – 2012. The analysis was conducted by a group of life insurance company real estate investment professionals coordinated by the ACLI. The data used was a national database of real property owned by investment fiduciaries and supplemented by data on real estate backing mortgage securities. The analysis is documented in a report to the NAIC dated April 9, 2017. In addition to modifying the factor for company owned and investment real estate, this updated factor will also be used for real estate acquired in satisfaction of debt (Foreclosed real estate) and for assets with the characteristics of real held estate (partnership or other structure) reported on Schedule BA. Foreclosed real estate is recognized in the statutory statements as having acquisition cost equal to market value at time of foreclosure. Schedule BA real estate was originally given a higher factor under a presumption that it was more highly levered. Analysis has shown these assets to have experience very similar to directly held and will therefore use the same factor.

While the experience analysis was done based on analysis of fair value impacts, Real Estate is reported at depreciated cost in the Statutory statements. Therefore, beginning in 2021 an adjustment is made to the factor to partially account for the difference between fair value and statutory carrying value on a property by property basis. The adjustment is defined as

Adj Factor = *RE Factor*(1 – [factor] * (MV-BVg)/BVg)}*

factor is [2/3]

The resulting adjusted RBC factor is subject to a minimum of zero. In the RBC calculation, see Figure 7, fair value is taken from Schedule A Column 10 plus encumbrances, or from Schedule BA column 11 plus encumbrances, respectively, while BVg is the net Book Adjusted Carrying Value plus the encumbrance.

Encumbrances have been included in the real estate base since the value of the property is held net of the encumbrance, but the entire value is subject to loss ~~would include encumbrances~~. Encumbrances receive ~~a~~the base real estate factor of [10%] reduced by the average factor for commercial mortgages of 1.75~~2~~ percent pre-tax. In the past this was computed as a base factor applied to the net real estate value plus a separate factor applied to the amount of the encumbrance. Beginning in 2021, the equivalent result will be obtained by applying a base factor to the gross statutory value of the property, and a credit provided for the amount of the encumbrance. ~~for real estate encumbrances not in foreclosure and 20 percent pre-tax for real estate encumbrances in foreclosure and encumbrances on Schedule BA real estate.~~

The final RBC amount is subject to a minimum of the Baa bond factor (1.30%) applied to the BACV, and a maximum of 45% of the BACV.

~~All references to involuntary reserves as it relates to real estate were removed to comply with the codification of statutory accounting principles.~~

Specific Instructions for Application of the Formula

Column (1)
Calculations are done on an individual property or joint venture basis in the worksheets and then the summary amounts are entered in this column for each class of real estate investment. Refer to the real estate calculation worksheet (Figure 7) for how the individual property or joint venture calculations are completed.

Line (18) should equal AVR Equity Component Column 1 Line 76.
Line (19) should equal AVR Equity Component Column 1 Line 77.
Line (20) should equal AVR Equity Component Column 1 Line 78.
Line (21) should equal AVR Equity Component Column 1 Line 79.

Low income housing tax credit investments are reported in Column (1) in accordance with *SSAP No. 93—Low Income Housing Tax Credit Property Investments*.

Column (2)
The average factor column is calculated as Column (3) divided by Column (1).

Column (3)
Summary amounts are entered for Column (3) based on calculations done on an individual property or joint venture basis. Refer to Column (8) of the real estate calculation worksheet (Figure 7).

Line (17)
Guaranteed federal low-income housing tax credit (LIHTC) investments are to be included in Line (17). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

Line (18)
Non-guaranteed federal LIHTC investments with the following risk mitigation factors are to be included in Line (18):

a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

Line (19)
State LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments.

Line (20)
State LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments.

Line (21)
State and federal LIHTC investments that do not meet the requirements of lines (17) through (20) would be reported on Line (21).

(Figure 7)

Real Estate Worksheet

Fair value adjustment factor [*factor*]

	(1) Description	(2) Book/Adjusted Carrying Value	(3) Encumbrances	(4) Fair Value	(5) Book/Adjusted Carrying Value Base Factor	(6) Encumbrances credit Factor	(7) Adjusted RBC Factor&	(8) Gross RBC Book/Adjusted Carrying Value Requirement‡	(9) Encumbrances Requirement§ Credit	(10) RBC Requirement*
	Company Occupied Real Estate									
(1)	All Properties Without Encumbrances†		XXX		0.105	XXX			XXX	
(1)										
(2)										
	All Properties With Encumbrances:									
(32)					0.105	0.0175				
(43)					0.105	0.0175				
(199)	Total Company Occupied Real Estate									
	Foreclosed Real Estate									
(1)	All Properties Without Encumbrances†		XXX		0.1023	XXX			XXX	
(1)										
(2)										
	All Properties With Encumbrances:									
(3)					0.1023	0.0175				
(4)					0.1023	0.0175				
(299)	Total Foreclosed Real Estate									
	Investment Real Estate									
(1)	All Properties Without Encumbrances†		XXX		0.1015	XXX			XXX	
(1)										
(2)										
	All Properties With Encumbrances:									

(3)(2)				0.1050	0.01750.120			
(4)(3)				0.1050	0.01750.120			
(399)	Total Investment Real Estate							
(499)	Total Real Estate (Line (199) + Line (299) + Line (399))							
	Schedule BA Assets with characteristics of Real Estate							
(1)	All Assets Without Encumbrances†All Joint Ventures w/o Encumbrances‡		XXX	0.1030	XXX		XXX	
(1)								
(2)								
	All Assets With Encumbrances:All Properties With Encumbrances:							
(3)(2)				0.1030	0.01750.200			
(4)(3)				0.1030	0.01750.200			
(899)	Total Schedule BA Real Estate							

Note that column (2) is the book/adjusted carrying value net of any encumbrances, while column (4) is the fair value of the property not reduced for any encumbrances.

† For each category, each property ~~Line (1) should also exclude properties or joint ventures that have a negative book/adjusted carrying value. These~~ should be listed individually, including those for which there is no encumbrance.

& Column (7) is Column (5) times (1-(*factor*) * (Column (4) – (Column (2) + Column (3))) / (Column (2) + Column (3))), but not less than zero.

‡ Column (86) is calculated as (Column (2) plus Column (3)) multiplied by Column (74).

§ Column (97) is calculated as Column (3) multiplied by Column (65).

* Column (108) is calculated as ~~the sum of~~ Column (86) minus~~plus~~ Column (97), but not less than ~~zero or more than Column (2).~~1.3% nor more than 45% of column (2), and not less than zero.

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Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE:	**1-28-21**
CONTACT PERSON:	**Crystal Brown**
TELEPHONE:	**816-783-8146**
EMAIL ADDRESS:	**cbrown@naic.org**
ON BEHALF OF:	**Health RBC (E) Working Group**
NAME:	**Steve Drutz**
TITLE:	**Chief Financial Analyst/Chair**
AFFILIATION:	**WA Office of Insurance Commissioner**
ADDRESS:	**PO Box 40255**
	Olympia, WA 98504-0255

FOR NAIC USE ONLY

Agenda Item # 2021-02-CA

Year 2021

DISPOSITION

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

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

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

DESCRIPTION OF CHANGE(S)

Incorporate references for "Incentives" under the managed care instructions and blank as "Bonuses/Incentives."

REASON OR JUSTIFICATION FOR CHANGE **

Currently the managed care instructions and blank only reference the bonuses, this change would clarify that both incentives and bonuses are to be included.

Additional Staff Comments:

02-10-21 cgb The Proposal was exposed to the Health Risk-Based Capital (E) Working Group for a 30-day comment period that ends on Mar. 12, 2021.
03-17-21 cgb No comments were received during the comment period. The Working Group referred the proposal to the Capital Adequacy (E) Task Force for a 30-day comment period for all lines of business, with any comments to come back to the Working Group.
03-23-21 cgb The Capital Adequacy (E) Task Force exposed the proposal for a 30-day comment period ending on 4/22/21.
4/23/21 cgb No comments were received during the exposure period.

**** This section must be completed on all forms.** **Revised 2-2019**

HEALTH

UNDERWRITING RISK – MANAGED CARE CREDIT
XR017

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase, or new arrangements may be added to the existing categories. The managed care categories are:

* Category 0 – Arrangements not Included in Other Categories
* Category 1 – Contractual Fee Payments
* Category 2 – Bonus and/or Incentives / Withhold Arrangements
* Category 3 – Capitation
* Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For 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) 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.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year's paid claims.

Line (1) – Category 0 – Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted FFS (based upon charges).
- Usual Customary and Reasonable (UCR) Schedules.
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Stop-loss payments by a health entity to its providers that are capitated or subject to withhold/incentive programs.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).

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This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (2) – Category 1 – Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, DRGs or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- RVS where the payment base and RV factor are fixed by contract for more than one year.
- Ambulatory payment classifications (APCs).

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (3) - Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives With No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE – **2019** Reporting Year

2018 withhold / bonus/incentive payments	750,000
2018 withholds / bonuses/incentives available	1,000,000
A. MCC Factor Multiplier	75% – Eligible for credit
2018 withholds / bonuses/incentives available	1,000,000
2018 claims subject to withhold - gross*	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claim payments subject to withhold - net** in the current year.

*** These are amounts due before deducting withhold or paying bonuses and/or incentives.**
**** These are actual payments made after deducting withhold or paying bonuses and/or incentives.**

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements. This amount should equal Exhibit 7, Part 1, Column 1, Line 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claim payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (5) – Category 3a – Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (6) – Category 3b – Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries. An *intermediary* is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a health entity and its enrollees via a separate contract between the intermediary and the health entity. This includes affiliates of a health entity that are not subject to RBC, except in those cases where the health entity qualifies for a higher managed care credit because the capitated affiliate employs providers and pays them non-contingent salaries, and where the affiliated intermediary has a contract only with the affiliated health entity. A *Regulated Intermediary* is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state.

Line (7) – Category 3c – Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claim payments in this category, which includes:

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0.)

Enter the amount of medical expense capitations paid to non-regulated intermediaries.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions

either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

Line (8) – Category 4 – Medical & Hospital Expense Paid as Salary to Providers**.** There is a managed care credit of 75 percent for claim payments in this category. Once claim payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on line 7 in the Underwriting Risk section should be deducted before applying the managed care credit factor. This category includes:

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities, which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with its affiliated health entity.
- All facilities related medical expenses and other non-provider medical costs generated within a health facility that is owned and operated by the health entity.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The "aggregate cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

This amount should equal Exhibit 7, Part 1, Column 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (9) – Sub-Total Paid Claims. The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental [should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement and the sum of Lines (8.3), (12) and (13) on page XR017 – Underwriting Risk – Managed Care Credit.

Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection**.** Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection**.** Category 1 for Medicare Part D Coverage would be all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection**.** Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection**.** Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (14) – Sub-Total Paid Claims**.** The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

Line (16) – Weighted Average Managed Care Discount. These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4) Line (14) divided by Column (2), Line (14).

Line (17) – Weighted Average Managed Care Risk Adjustment Factor**.** These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor. These do not apply to Medicare Part D coverage.

Line (18) – Withhold & Bonus/Incentive Payments**, *prior year*.** Enter the prior year's actual withhold and bonus/incentive payments.

Line (19) –Withhold & Bonuses/Incentives Available**, *prior year*.** Enter the prior ~~year's~~years withholds and bonuses/incentives that were available for payment in the prior year.

Line (20) – MCC Multiplier – Average Withhold Returned**.** Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21) – Withholds & Bonuses/Incentives Available, ***prior year*.** Equal to Line (19) and is automatically pulled forward.

Line (22) – Claims Payments Subject to Withhold, ***prior year*.** Claim payments that were subject to withholds and bonuses/incentives in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) – Average Withhold Rate, ***prior year*.** Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) – MCC Discount Factor, Category 2**.** Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health ~~entity's~~entities withhold/bonus/incentive program in the prior year.

LIFE

UNDERWRITING RISK - MANAGED CARE CREDIT

LR022

This worksheet LR022 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the comprehensive medical dental business, Stand-Alone Medicare Part D Coverage or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- Category 0 - Arrangements not Included in Other Categories
- Category 1 - Contractual Fee Payments
- Category 2 – Bonus and/or incentives / Withhold Arrangements
- Category 3 - Capitation
- Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

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) 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.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year's paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to insure that true risk transfer is accomplished.

Line (1)

Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

- Fee for service (charges).
- Discounted fee for service (based upon charges).

- Usual customary and reasonable (UCR) schedules.
- Relative value scale (RVS), where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
- Claim payments not included in other categories.

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Line (2)

Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

- Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
- Non-adjustable professional case and global rates.
- Provider fee schedules.
- Relative value scale (RVS), where the payment base and RV factor are fixed by contract for more than one year.

Line (3)

Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentives/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE - 1998 Reporting Year	
1997 withhold / bonus/incentive payments	750,000
1997 withholds / bonuses/incentives available	1,000,000
A . MCC Factor Multiplier	75% - Eligible for credit
1997 withholds / bonuses/incentives available	1,000,000
1997 claims subject to withhold -gross†	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.

‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

Line (4)

Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a provider fee schedule (Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum of Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitation or percent of premium payments to regulated intermediaries that, in turn, pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 2 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

- All capitated or percent of premium payments to non-affiliated intermediaries that, in turn, pay licensed providers (subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations that meet the definition in Appendix 2 for Intermediary but not regulated intermediary. In those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater

of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions either within or beyond a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for both providers and intermediaries.

Line (8)
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

- Non-contingent salaries to persons directly providing care.
- The portion of payments to affiliated entities passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
- All facilities-related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
- Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as “medical expense” payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

Line (9)
Subtotal Paid Claims – The total of Column (2) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line A.4 of the annual statement.

Line (10)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11)
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (12)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (16)
Weighted Average Managed Care Discount – The amounts in Column (3) and Column (4) are calculated by dividing the total weighted claims in Column (3) by the total claims paid in Column (2) for Lines (9) and (14) respectively.

Line (17)

Weighted Average Managed Care Risk Adjustment Factor – These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (16)).

Lines (18) through (24)
Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (18)
Enter the prior year's actual withhold and bonus/incentive payments.

Line (19)
Enter the prior year's withholds and bonuses/incentives that were available for payment in the prior year.

Line (20)
Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21)
Equal to Line (19) and is automatically pulled forward.

Line (22)
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of LR022 Underwriting Risk – Managed Care Credit FOR THE PRIOR YEAR.

Line (23)
Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24)
Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer's withhold/bonus/incentive program in the prior year.

PR021 - Underwriting Risk – Managed Care Credit

This worksheet PR021 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical, Stand-Alone Medicare Part D Coverage, Dental business or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between coverages subject to the managed care credit and pure indemnity insurance. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

There are currently five levels of managed care that are used in the RBC formulas other than for Stand-Alone Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

* Category 0 - Arrangements not Included in Other Categories
* Category 1 - Contractual Fee Payments
* Category 2 – Bonus and/or Incentives / Withhold Arrangements
* Category 3 - Capitation
* Category 4 - Non-contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

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) 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.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care "buckets" to determine the weighted average discount, which is then used to reduce the Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category.

In some instances, claims payments may fit into more than one category. If that occurs, enter the claims payments into the highest applicable category. CLAIMS PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claims payments reported in the managed care worksheet should equal the total year's paid claims. Category 2a, Category 2b and Category 3c are not allowed to include non-regulated intermediaries who are affiliated with the reporting company in order to ensure that true risk transfer is accomplished.

Line (1)

Category 0 - Arrangements not Included in Other Categories. There is a zero managed care credit for claim payments in this category, which includes:

* Fee for service (charges).
* Discounted fee for service (based upon charges).
* Usual customary and reasonable (UCR) schedules.
* Relative value scale (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.

* Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
* Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
* Claim payments not included in other categories.

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Line (2)

Category 1 - Payments Made According to Contractual Arrangements. There is a 15 percent managed care credit for payments included in this category:

* Hospital per diems, diagnostic related groups (DRGs) or other hospital case rates.
* Non-adjustable professional case and global rates.
* Provider fee schedules.
* Relative value scale (RVS) where the payment base and RV factor are fixed by contract for more than one year.

Line (3)

Category 2a - Payments Made Subject to Withholds or Bonuses/Incentives with No Other Managed Care Arrangements. This category may include business that would have otherwise fit into Category 0. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a UCR schedule (Category 0).

The maximum Category 2a managed care credit is 25 percent. The credit is based upon a calculation that determines the ratio of withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds and bonuses and incentives available to the providers during that year. That ratio is then multiplied by the average provider withhold ratio for the prior year to determine the current year's Category 2a managed care credit factor. Bonus and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to the result of the following calculation:

EXAMPLE - 1998 Reporting Year	
1997 withhold / bonus payments	$750,000
1997 withholds / bonuses available	$1,000,000
A. MCC Factor Multiplier	75% - Eligible for credit
1997 withholds / bonuses available	$1,000,000
1997 claims subject to withhold -gross†	$5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

The resulting factor is multiplied by claims payments subject to withhold - net‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses and/or incentives.

‡ These are actual payments made after deducting withhold or paying bonuses and/or incentives.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives, but otherwise had no managed care arrangements.

Line (4)

Category 2b - Payments Made Subject to Withholds or Bonuses/Incentives That Are Otherwise Managed Care Category 1. Category 2b may include business that would have otherwise fit into Category 1. That is, there may be a bonus/incentive/withhold arrangement with a provider who is reimbursed based on a provider fee schedule

(Category 1). The Category 2 discount for claims payments that would otherwise qualify for Category 1 is the greater of the Category 1 factor or the calculated Category 2 factor.

The maximum Category 2b managed care credit is 25 percent. The minimum Category 2b managed care credit is 15 percent (Category 1 credit factor). The credit calculation is the same as found in the previous example for Category 2a.

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses/incentives AND where the payments were made according to one of the contractual arrangements listed for Category 1.

Line (5)
Category 3a - Capitated Payments Directly to Providers. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments made directly to licensed providers.

Enter the amount of claims payments paid DIRECTLY to licensed providers on a capitated basis.

Line (6)
Category 3b - Capitated Payments to Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitation or percent of premium payments to regulated intermediaries that in turn pay licensed providers.

Enter the amount of medical expense capitations paid to regulated intermediaries (see Appendix 1 for definition). In those cases where the capitated regulated intermediary employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

Line (7)
Category 3c - Capitated Payments to Non-Regulated Intermediaries. There is a managed care credit of 60 percent for claims payments in this category, which includes:

* All capitated or percent of premium payments to non-affiliated intermediaries that in turn pay licensed providers. (Subject to a 5 percent limitation on payments to providers or other corporations that have no contractual relationship with such intermediary. Amounts greater than the 5 percent limitation should be reported in Category 0).

Enter the amount of medical expense capitations paid to non-regulated intermediaries not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition of Intermediary but not regulated intermediary in Appendix 1. In cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 1 for a provider, and for an intermediary at the greater of Category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive

revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under Category 0 for providers and intermediaries.

Line (8)
Category 4 - Medical & Hospital Expense Paid as Salary to Providers. There is a managed care credit of 75 percent for claims payments in this category. Once claims payments under this managed care category are totaled, any fee for service revenue from uninsured plans (i.e., ASO or ASC) that was included on Line (7) in the underwriting risk section should be deducted before applying the managed care credit factor.

* Non-contingent salaries to persons directly providing care.
* The portion of payments to affiliated entities which is passed on as non-contingent salaries to persons directly providing care where the entity has a contract only with the company.
* All facilities related medical expenses and other non-provider medical costs generated within health facility that is owned and operated by the insurer.
* Aggregate cost payments.

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as "medical expense" payments (paid claims) rather than administrative expenses. The Aggregate Cost method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, that put their respective capital and surplus at risk in guaranteeing each other.

Line (10.1)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (10.2)
Category 1 for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (10.3)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (10.4)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (10.6)
Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line D16 of the annual statement.

Line (11)
Weighted Average Managed Care Discount – This amount is calculated by dividing the total weighted claims (Line (9) Column (2)) by the total claim payments (Line (9) Column (1).

Line (12)

Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (11)).

Lines (13) through (19)
Lines (13) through (19) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (13)
Enter the prior year's actual withhold and bonus/incentive payments.

Line (14)
Enter the prior year's withholds and bonuses/incentives that were available for payment in the prior year.

Line (15)
Divides Line (13) by Line (14) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (16)
Equal to Line (14) and is automatically pulled forward.

Line (17)
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of Underwriting Risk–Managed Care Credit FOR THE PRIOR YEAR.

Line (18)
Divides Line (16) by Line (17) to determine the average withhold rate for the prior year.

Line (19)
Multiplies Line (15) by Line (18) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer's withhold/bonus/incentive program in the prior year.

HEALTH, LIFE AND PROPERTY AND CASUALTY

APPENDIX 1 – COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

Incentives, Withhold and Bonus Amounts – Are amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. An incentive arrangement may involve paying an agreed-on amount for each claim (e.g. provider agrees practice in an underserved area). While a bonus arrangement may be paid at the end of a contact period after specific goals have been met. Withhold arrangements can involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

Incentive pool, withhold, and bonus amounts are defined as: amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. Some arrangements involve paying an agreed-on amount for each claim, and then paying a bonus at the end of the contract period. Other arrangements involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

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Commented [BC1]: This could also be worded as "(e.g. provider is paid on a per claim basis for practicing in an underserved area.)"

Commented [BC2]: This is directly from the A/S instructions. It used as a basis for the definition drafted above.

UNDERWRITING RISK - Managed Care Credit Calculation

	Managed Care Claims Payments	Annual Statement Source	(1) Factor	(2) Paid Claims	(3) Weighted Claims†	(4) Part D Weighted Claims‡
(1)	Category 0 - Arrangements not Included in Other Categories	Exhibit 7, Part 1, Column 1, Line 5, in part §	0			
(2)	Category 1 - Payments Made According to Contractual Arrangements	Exhibit 7, Part 1, Column 1, Line 6, in part §	0.150			
(3)	Category 2a - Subject to Withholds or Bonuses/**Incentives** - Otherwise Categc	Exhibit 7, Part 1, Column 1, Line 7, in part §	*			
(4)	Category 2b - Subject to Withholds or Bonuses/**Incentives** - Otherwise Categc	Exhibit 7, Part 1, Column 1, Line 8, in part §	*			
(5)	Category 3a - Capitated Payments Directly to Providers		0.600			
(5.1)	Capitation Payments - Medical Group - Category 3a	Exhibit 7, Part 1, Column 1, Line 1, in part §				
(5.2)	Capitation Payments - All Other Providers - Category 3a	Exhibit 7, Part 1, Column 1, Line 3, in part §				
(6)	Category 3b - Capitated Payments to Regulated Intermediaries	Included in Exhibit 7, Part 1, Column 1, Line 2 §	0.600	$0		
(7)	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Included in Exhibit 7, Part 1, Column 1, Line 2 §	0.600	$0		
(8)	Category 4 - Medical & Hospital Expense Paid as Salary to Providers		0.750			
(8.1)	Non-Contingent Salaries - Category 4	Exhibit 7, Part 1, Column 1, Line 9, in part §				
(8.2)	Aggregate Cost Arrangements - Category 4	Exhibit 7, Part 1, Column 1, Line 10, in part §				
(8.3)	Less Fee For Service Revenue from ASC or ASO	Company Records				
(9)	Sub-Total Paid Claims	Exhibit 7, Part 1, Column 1, Lines 13 - 11 - (8.3) - (12) - (13)				
	Stand-Alone Medicare Part D Coverage Claim Payments					
(10)	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company Records	XXX	XXX		XXX
(11)	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company Records	XXX	XXX		XXX
(12)	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company Records	0.667			
(13)	Category 3a - Federal Reinsurance and Risk Corridor Protection Apply	Company Records	0.767			
(14)	Sub-Total Paid Claims	Sum of Lines (10) through (13)				
(15)	Total Paid Claims	Sum of Lines (9) and (14)				
(16)	Weighted Average Managed Care Discount					
(17)	Weighted Average Managed Care Risk Adjustment Factor					

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision Managed Care Discount factor.

‡ This column is for the Medicare Part D Managed Care Discount factor.

§ Stand-Alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.

* The factor is calculated on page XR018.

Denotes items that must be manually entered on filing software.

		Annual Statement Source	(1) Amount
*** Calculation of Category 2 Managed Care Factor**			
(18)	Withhold & Bonus/**Incentive** Payments, ***Prior Year***	Company Records	
(19)	Withhold & Bonuses/**Incentives** Available, ***Prior Year***	Company Records	
(20)	MCC Multiplier - Average Withhold Returned [Line (18)/(19)]		
(21)	Withholds & Bonuses/**Incentives** Available, ***Prior Year***	Company Records	
(22)	Claims Payments Subject to Withhold, ***Prior Year***	Company Records	
(23)	Average Withhold Rate, Prior Year [Line (21)/(22)]		
(24)	MCC Discount Factor, Category 2 Min{.25,[Lines (20) x (23)]}		

* The factor is pulled into Lines (3) and (4) on page XR017.

Denotes items that must be manually entered on filing software.

UNDERWRITING RISK – MANAGED CARE CREDIT

	Comprehensive Medical, Medicare Supplement and Dental Claim Payments	Annual Statement Source	(2) Paid Claims		Factor		(3) Weighted Claims*	(4) Part D Weighted Claims**
(1)	Category 0 - Arrangements not Included in Other Categories	Company records		X	0.000	=		
(2)	Category 1 - Payments Made According to Contractual Arrangements	Company records		X	0.150	=		
(3)	Category 2a - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category 0	Company records		X	†	=		
(4)	Category 2b - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category 1	Company records		X	‡	=		
(5)	Category 3a - Capitated Payments Directly to Providers	Company records		X	0.600	=		
(6)	Category 3b - Capitated Payments to Regulated Intermediaries	Company records		X	0.600	=		
(7)	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Company records		X	0.600	=		
(8)	Category 4 - Medical & Hospital Expense Paid as Salary to Providers	Company records		X	0.750	=		
(9)	Subtotal Paid Claims	Sum of Lines (1) through (8)						
	Stand-Alone Medicare Part D Coverage Claim Payments							
(10)	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company records	XXX	X	xxx	=		XXX
(11)	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company records	XXX	X	xxx	=		XXX
(12)	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company records		X	0.667	=		
(13)	Category 3a - Federal Reinsurance and Risk Corridor Protection apply	Company records		X	0.767	=		
(14)	Subtotal Stand-Alone Medicare Part D Paid Claims	Sum of Lines (10) through (13)						
(15)	Total Paid Claims	Line (9) + Line (14)						
(16)	Weighted Average Managed Care Discount	Column (3) = Column (3) Line (9) / Column (2) Line (9); Column (4) = Column (4) Line (14) / Column (2) Line (14)						
(17)	Weighted Average Managed Care Risk Adjustment Factor	1.0 - Line (16)						

	Calculation of Category 2 Managed Care Factor (Comprehensive Medical and Dental only)		(1) Amount
(18)	Withhold & bonus/**incentive** payments, prior year	Company Records	
(19)	Withhold & bonuses/**incentives** available, prior year	Company Records	
(20)	Managed Care Credit Multiplier – average withhold returned	Line (18) / Line (19)	
(21)	Withholds & bonuses/**incentives** available, prior year	Line (19)	
(22)	Claims payments subject to withhold, prior year	Company Records	
(23)	Average withhold rate, prior year	Line (21) / Line (22)	
(24)	Managed Care Credit Discount Factor, Category 2	Minimum of 0.25 or Line (20) x Line (23)	

† Category 2 Managed Care Factor calculated on Line (24).

‡ Category 2 Managed Care Factor calculated on Line (24) with a minimum factor of 15 percent.

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

** This column is for the Stand-Alone Medicare Part D managed care discount factor.

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

UNDERWRITING RISK - MANAGED CARE CREDIT PR021

	Comprehensive Medical, Medicare Supplement and Dental & Vision Claim Payments	Annual Statement Source	(2) Paid Claims	Factor	(3) Weighted Claims†	(4) Part D Weighted Claims††
(1)	Category 0 - Arrangements not Included in Other Categories	Company records	0	0.000	0	
(2)	Category 1 - Payments Made According to Contractual Arrangements	Company records	0	0.150	0	
(3)	Category 2a - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category (	Company records	0	*	0	
(4)	Category 2b - Subject to Withholds or Bonuses/**Incentives** – Otherwise Category	Company records	0	**	0	
(5)	Category 3a - Capitated Payments Directly to Providers	Company records	0	0.600	0	
(6)	Category 3b - Capitated Payments to Regulated Intermediaries	Company records	0	0.600	0	
(7)	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Company records	0	0.600	0	
(8)	Category 4 - Medical & Hospital Expense Paid as Salary to Providers	Company records	0	0.750	0	
(9)	Sub-Total Paid Claims	Sum of Lines (1) through (8)	0		0	
	Stand-Alone Medicare Part D Coverage Claim Payments					
(10.1)	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company records	XXX	XXX		XXX
(10.2)	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company records	XXX	XXX		XXX
(10.3)	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company records	0	0.667		0
(10.4)	Category 3a - Federal Reinsurance and Risk Corridor Protection apply	Company records	0	0.767		0
(10.5)	Sub-Total Paid Claims	Sum of Lines (10.1) through (10.4)	0			0
(10.6)	Total Paid Claims	Sum of Lines (9) and (10.5)	0			
(11)	Weighted Average Managed Care Discount	Col (3) = Col (3) Line (9) / Col (2) Line (9) Col (4) = Col (4) Line (10.5) / Col (2) Line (10.5)			0.000	0.000
(12)	Weighted Average Managed Care Risk Adjustment Factor	Col (3) = 1.0 - Col (3) Line (11) Col (4) = 1.0 - Col (4) Line (11)			0.000	0.000

	Calculation of Category 2 Managed Care Factor		(1) Amount
(13)	Withhold & bonus/**incentive** payments, prior year	Company Records	0
(14)	Withhold & bonuses/**incentives** available, prior year	Company Records	0
(15)	Managed Care Credit Multiplier – average withhold returned	Line (13) / Line (14)	0.000
(16)	Withholds & bonuses/**incentives** available, prior year	Line (14)	0
(17)	Claims payments subject to withhold, prior year	Company Records	0
(18)	Average withhold rate, prior year	Line (16) / Line (17)	0.000
(19)	Managed Care Credit Discount Factor, Category 2	Minimum of 0.25 or Line (15) x Line (18)	0.000

* Category 2 Managed Care Factor calculated on Line (19)

**Category 2 Managed Care Factor calculated on Line (19) with a minimum factor of 15 percent.

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

†† This column is for the Stand-Alone Medicare Part D managed care discount factor.

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

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Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE:	**2/28/21**
CONTACT PERSON:	**Eva Yeung**
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EMAIL ADDRESS:	**eyeung@naic.org**
ON BEHALF OF:	**P/C RBC (E) Working Group**
NAME:	**Tom Botsko**
TITLE:	**Chair**
AFFILIATION:	**Ohio Department of Insurance**
ADDRESS:	**50 West Town Street, Suite 300**
	Columbus, OH 43215

FOR NAIC USE ONLY

Agenda Item # 2021-03-P

Year 2021

DISPOSITION

[ ] ADOPTED _____

[ ] REJECTED _____

[ ] DEFERRED TO _____

[ ] REFERRED TO OTHER NAIC GROUP

[x] EXPOSED 3/15/21

[ ] OTHER (SPECIFY) _____

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

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

DESCRIPTION OF CHANGE(S)

Adding examples as a guide to portray the intent of the R3 ratings instructions.

REASON OR JUSTIFICATION FOR CHANGE **

The proposed instruction changes would provide examples to clarify how the reporting companies should select the designation in the Annual Statement Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies.

Additional Staff Comments:

3/15/21 – The PCRBC WG exposed this proposal for a thirty-day public comment period ending Apr. 14.

**** This section must be completed on all forms.** **Revised 2-2019**

PR012 - Credit Risk for Receivables

Reinsurance Recoverables

The calculation of the credit risk charge for reinsurance recoverables is detailed in Schedule F Part 3 Columns 28 through 36 of the Property/Casualty Annual Statement. This calculation is performed at the transaction level and those results are then summed to determine the charge. Reinsurance balances receivable on reinsurance ceded to non-affiliated companies (excluding certain pools) and to alien affiliates are subject to the credit risk-based capital charge. The following types of cessions are exempt from this charge:

- Cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs.
- This category includes all federal insurance programs [e.g., National Flood Insurance Program (NFIP), Federal Crop Insurance Corporation (FCIC), etc., all state mandated residual market mechanisms and the National Council on Compensation Insurance (NCCI].
- Cessions to U.S. Parents, Subsidiaries and Affiliates.

The categories above are automatically excluded from the data that is calculated in Schedule F Part 3 of the Annual Statement.

Since the Annual Statement requires the collectability of reinsurance balances be considered via the reinsurance penalty, the appropriate balances must be offset by any liability that has been established for this purpose. The amount from Page 3, Line 16 should be allocated to the appropriate (re)insurers listed on Schedule F. The total amount recoverable from reinsurers less any applicable reinsurance penalty is multiplied by 120% to stress the recoverable balance. The total of reinsurance payable and/or funds held amounts (not in excess of the stressed recoverable) are applied as offsets to arrive at the stressed net recoverable.

Since there are different reinsurance credit risk factors for collateralized and uncollateralized reinsurance recoverables, the stressed net recoverable should be offset by any available collateral, such as letters of credit, multiple beneficiary trusts, and single beneficiary trusts and other allowable offsets (not in excess of the stressed net recoverable). The collateralized amounts are derived from Schedule F Part 3 Column 32 and the uncollateralized amounts are derived from Column 33.

The risk-based capital for the various credits (including collateral offsets where applicable) taken for reinsurance may not be less than zero even if the amount reported or the amount net of offsets is negative.

The factor for reinsurance recoverables (paid and unpaid less any applicable reinsurance penalty) due from a particular reinsurer is determined based on that reinsurer's financial strength rating assigned on a legal entity basis.

For the purpose of the credit risk-based capital charge, the equivalent rating category assigned will correspond to current financial strength rating received from **one of the** approved rating **agencies** as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the **reinsurer** and shall not be based solely on publicly available information. If the reinsurer does not have at least one financial strength rating, it should be assigned the "Vulnerable 6 or Unrated" equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the "Secure 3" equivalent rating.

For authorized association**s** including incorporated and individual unincorporated underwriters or a member thereof (e.g. individual authorized syndicates of Lloyds' of London that are backed by the Central Fund) utilize the lowest financial strength group rating received from an approved rating agency.

For authorized associations, including incorporated and individual unincorporated underwriters or a member thereof (e.g. individual authorized syndicates of Lloyds' of London that are backed by the Central Fund), may utilize the lowest financial strength group rating received from an approved rating agency.

The table below shows the R3 reinsurer equivalent rating categories and corresponding factors for A.M. Best, Standard and Poor's, Moody's and Fitch ratings.

Reinsurer Designation Equivalent Rating Category and Corresponding Factors—For RBC R3 Credit Risk Charge

Description	Secure 1	Secure 2	Secure 3	Secure 4	Secure 5	Vulnerable 6 or Unrated
A.M. Best	A++	A+	A	A-	B++, B+	B, B-, C++, C+, C, C-, D, E, F
Standard & Poor's	AAA	AA+, AA, AA-	A+, A	A-	BBB+, BBB, BBB-	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R
Moody's	Aaa	Aa1, Aa2, Aa3	A1, A2	A3	Baa1, Baa2, Baa3	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C
Fitch	AAA	AA+, AA, AA-	A+, A	A-	BBB+, BBB, BBB-	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R
Collateralized Amounts Factors	3.6%	4.1%	4.8%	5.0%	5.0%	5.0%
Uncollateralized Amounts Factors	3.6%	4.1%	4.8%	5.3%	7.1%	14.0%

Each reporting company should record in Schedule F Part 3, Column 34, the reinsurer designation equivalent financial strength ratings assigned to the (re)insurers listed, where there are balances receivable on reinsurance ceded for the Schedule F categories subject to the credit risk charge on reinsurance recoverables. The resulting credit risk charge for reinsurance recoverables is determined by applying the corresponding factor by reinsurer designation equivalent to the collateralized and uncollateralized balances respectively. These respective charges are derived from Schedule F Part 3, Columns 35 and 36 and Line 9999999 totals are reported on PR012 Lines 1 and 2. **See examples below.**

Miscellaneous Recoverables

There is risk associated with recoverability of amounts from creditors other than reinsurers. In addition to the default risk, there is the risk that the amounts are not accurately estimated. The factor to measure this risk is estimated at 5 percent for Amounts Receivable Relating to Uninsured Accident and Health Plans; Receivables from Parent, Subsidiaries and Affiliates; and Aggregate Write-ins for Other Than Invested Assets. For Interest, Dividends and Real Estate Income Due and Accrued, which for the most part represents interest income due and accrued from bond holdings, the charge is 1 percent, which is equivalent to the charge applicable to unaffiliated NAIC 02 bonds.

Examples: The following examples are here as a guide to portray the intent of these instructions.

These examples assume that all financial strength ratings are from one of the rating agencies listed in the table above and there is interactive communication between the rating agency and the reinsurer unless stated otherwise.

Example 1—Reinsurer has only one rating: Assume the Reinsurer XYZ has a financial strength rating of A from A.M. Best. This falls in the Secure 3 category and the reporting company should select this category and corresponding charge.

Example 2—Reinsurer has more than one rating: Assume the Reinsurer XYZ has a financial strength rating of "A" from A.M. Best and another rating of "AAA" from Fitch. The reporting company may use either of the ratings provided by A.M. Best or Fitch.

Example 3—Reinsurer only has a Public Information Rating: Ratings that include the symbol of "pi" (e.g. Api), which indicates a public information rating, are not allowed to be used. If a reinsurer has only been assigned Public Information ratings, meaning no other financial strength ratings have been assigned to it; then the reporting company must list the reinsurer's rating as Vulnerable 6 or Unrated.

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

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

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
				Ongoing Items – Life RBC			
1	Life RBC WG	Ongoing	Ongoing	Make technical corrections to Life RBC instructions, blank and /or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.			
2	Life RBC WG	1	2021 or later	1.Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2.Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.	CATF	Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup	
3	Life RBC WG	1	2021 or later	Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate.	New Jersey	Being addressed by the Longevity (E/A) Subgroup	
				Carry-Over Items Currently being Addressed – Life RBC			
4	Life RBC WG	1	2021 or later	Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities **with consideration of contingent deferred annuities as well**	AAA		
~~5~~	~~Life RBC WG~~	~~1~~	~~2021~~	~~Determine if any adjustment is needed to the XXX/AXXX RBC Shortfall calculation to address surplus notes issued by captives.~~	~~11/1/17 Referral from the Reinsurance (E) Task Force~~		~~3/24/2018~~
~~6~~	~~Life RBC WG~~	~~1~~	~~2021~~	~~Determine if any adjustment is needed due to the changes made to the Life and Health Guaranty Association Model Act, Model #520.~~			~~9/1/2018~~
~~7~~ 5	Life RBC WG	1	2021	Determine if any adjustment is needed to the reinsurance credit risk in light of changes related to collateral and the changes made to the property RBC formula.			9/1/2018
~~8~~ 6	Life RBC WG	1	2021	Discuss and determine the bond factors for the 20 designations.	Referral from Investment RBC July/2020		
~~9~~ 7	Life RBC WG	1	2021	Discuss and determine the need to adjust the real estate factors.	Referral from Investment RBC July/2020		
				New Items – Life			
~~10~~ 8	Life RBC WG	1	2021 or later	Work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation.			
				Carry-Over Items Currently being Addressed – P&C RBC			
9	Cat Risk SG	1		Continue development of RBC formula revisions to include a risk charge based on catastrophe model output:			
			Year-end 2022 or later	a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.	**Referral from the Climate and Resiliency Task Force. March 2021**	**4/26/21 - The SG expose the referral for a 30-day exposure period.**	**4/26/2021**

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

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

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
10	P&C RBC WG	1	Year-end 2020 or later	Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsures that do not trigger growth risk in their own right.	Refer from Operational Risk Subgroup	1) Sent a referral to the Academy on 6/14/18 conference call.	1/25/2018
11	P&C RBC WG	1	2020 Summer Meeting or later	Continue development of RBC formula revisions based on the Covered Agreement: 'a) consider eliminating the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers; 'b) consider whether the factor for uncollateralized, unrated reinsurers, runoff and captive companies should be adjusted		12/5/19 - The WG exposed Proposal 2018-19-P (Vulnerable 6 or unrated risk charge) for a 30-day exposure period. 2/3/20 - The WG adopted Proposal 2018-19-P. However, the WG intended to evaluate the data annually until reaching any agreed upon change to the factor and the structure. 3/15/21 - The WG exposed Proposal 2021-03-P (Credit Risk Instruction Modification) for a 30-day exposure period.	8/4/2018
12	P&C RBC WG	1	Year-end 2021 or later	Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments			6/10/2019
13	P&C RBC WG	1	2021 Summer Meeting or later	Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.			6/10/2019
14	Cat Risk SG	1	Year-end 2020 or later	Evaluate the possibility of allowing additional third party models or adjustments to the vendor models to calculate the cat model losses			12/6/2019
15	P&C RBC WG	1	2021 Spring Meeting	Evaluate if changes should be made to the P/C formula to better assess companies in runoff.		1/29/20 - received a referral from the Restructuring Mechanisms (E) WG	2/3/2020
16	P&C RBC WG	1	2021 Spring Meeting	Evaluate the Underwriting Risk Line 1 Factors in the P/C formula.			7/30/2020
17	Cat Risk SG	1	2021 Spring Meeting	Modify instructions to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories		10/27/20 - expose the propsal for 30 day comment period	10/19/2020
18	P&C RBC WG/Cat Risk SG	1	2021 Spring Meeting	Remove the embedded 3% operational risk component contained in the reinsurance contingent credit risk factor of Rcat		10/27/20 - expose the propsal for 35 day comment period	10/27/2020
19	P&C RBC WG	1	2021 Summer Meeting	Evaluate R3 Adjustment for Operational Risk Charge			10/27/2020
				New Items – P&C RBC			
20	Cat Risk SG	1	2022 Spring Meeting or later	Implement Wildfire Peril in the Rcat component (For Informational Purpose Only)			3/8/2021

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
				Ongoing Items – Health RBC			
21	Health RBC WG	3	Year-end 2022 RBC or later	Evaluate the impact of Federal Health Care Law on the Health RBC Formulas	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula as a result of ongoing federal discussions and legislation.	
22	Health RBC WG	3	Year-end **2022** RBC or later	Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales	HRBCWG	Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
				Carry-Over Items Currently being Addressed – Health RBC			
23	Health RBC WG	3	Year-End 2023 RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA	
24	Health RBC WG	2	Year-end 2023 RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to the Blanks (E) Working Group	
25	Health RBC WG	1	Year-end 2022 or later	Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks	HRBCWG	Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks.	8/4/2018
26	Health RBC WG	1	Year-end 2022 RBC or later	Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. Review Managed Care Credit across formulas.	HRBCWG	Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 & 1 to 2a and 2b.	12/3/2018
27	Health RBC WG	1	Year-end 2022 or later	Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
28	Health RBC WG	1	Year-End 2022 or later	Consider impact of COVID-19 and pandemic risk in the Health RBC formula.	HRBCWG		7/30/2020

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

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

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
29	Health RBC WG	1	Year-End 2021 or later	Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula.	HRBCWG	Referral Letter was sent to the Academy on Sept 21.	8/18/2020
30	Health RBC WG	1	2021	Discuss and determine the bond factors for the 20 designations.	Referral from Investment RBC July/2020	Working Group will use two- and five-year time horizon factors in 2020 impact analysis.	9/11/2020
				New Items – Health RBC			
31	**Health RBC WG**	**1**	**Year-End 2022 or later**	**Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18 above)**	**HRBCWG**		**4/23/2021**
				New Items – Task Force			
				Ongoing Items – Task Force			
32	CADTF	1	2022 or Later	Supplementary Investment Risks Interrogatories (SIRI)	Referral from Blackrock and IL DOI	The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and the TF will conduct a holistic review all investment referrals.	11/19/2020
33	CADTF	1	2021	Consideration given to 20 designations for bonds in all RBC formulas so that an impact analysis can be provided on 2020 year-end data to determine the bond RBC factors. The Task Force will need to discuss and determine whether Hybrids are included with the new bond's structure. History In 2012 /13 as part of the Solvency Modernization Initiative "roadmap" and subsequent White Paper roadmap, the Capital Adequacy (E) Task Force identified increased granularity in the asset and investment risk charges as a priority area. It was originally targeted at the Life RBC formula and was referred to as the "C1 factor review". The project was assigned to a newly formed Investment RBC (E) Working Group in 2013. Work was conducted by the Life C-1 Work Group of American Academy of Actuaries (Academy) at the instructions of the working group using defined criteria for the analysis: The C1 bond factors are defined as the amount needed to pre-fund losses at the 96th percentile minus the amount assumed to be funded in statutory policy reserves. The credit loss distribution is skewed with the mean occurring at approximately the 60th percentile. The RP does not vary by economic scenario.	IRBCWG - Dec 2019	An Academy report issued in 2015 and updated 2017 report recommended an increase in the number of designations. Ultimately, the WG members agreed that the number of designations should be increased to 20. In 2017//2018, the PRBC and HRBC (E) Working Groups began discussion of the change to 20 designations. In 2019 both working groups concurred with the LRBC WG position that the number of designations should be increased to 19 in their respective formulas Proposal # 2019 – 16CA Factors are Exposed for Comment and will be considered on the June 30th CADTF call.	
34	CADTF	2	2022	Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016	Ad Hoc Group	Ad Hoc group will provide periodic updates on their progress.	
				Carry-Over Items not Currently being Addressed – Task Force			

2020 #	Owner	2020 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
35	CADTF	3	2021	Receivable for Securities factor		Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) **Factors are exposed for comment. Comments due May 28, 2021 for consideration on June 30th.**	
36	CADTF	3	2022 or Later	NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge? Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.	Referral from SAPWG 8/13/2018	10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.	10/11/2018
37	CADTF	3	2022 or Later	Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure.	Referral from SAPWG April 16, 2019	10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.	8/4/2019
38	CADTF	3	2022 or Later	Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2	Referral from VOSTF 9/21/2018	Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.	11/16/2018

Carry-Over Items Currently being Addressed – Task Force

~~39~~	~~CADTF~~	~~2~~	~~2020 or Later~~	~~XXX/AXXX Captive Reinsurance RBC Shortfall~~	~~Referral from Reinsurance Task Force /RITF~~	~~Referred to Life RBC WG for consideration and comment~~	~~11/1/2017~~
~~40~~	~~CADTF~~	~~2~~	~~2020 or Later~~	~~Payout Annuities for RBC~~	~~Referral from Allstate and IL DOI~~	~~Referred to Life RBC WG for consideration and comment~~	~~3/25/2018~~
~~41~~	~~CADTF~~	~~2~~	~~2020 or Later~~	~~Guaranty Association Assessment Risk~~	~~Referral from Receivership and Insolvency (E) Task Force 5/1/2018~~	~~Referred to the Life RBC WG and Health RBC WG for consideration and comment.~~	~~6/30/2018~~