Draft date: 10/30/25

Virtual Meeting

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP
Thursday, November 6, 2025
12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

Steve Drutz, Chair	Washington	John Rehagen/ Danielle Smith	Missouri
Matthew Richard, Vice Chair	Texas		
Wanchin Chou	Connecticut	Margaret Otto	Nebraska
Kyle Collins	Florida	Michel Laverdiere	New York
Tish Becker	Kansas	Diana Sherman	Pennsylvania

NAIC Support Staff: Derek Noe/Maggie Chang

AGENDA

1. Consider Adoption of its Sept. 29 and June 20 Minutes —*Steve Drutz (WA)* — Attachment 1, Attachment 2
2. Consider Adoption of its Working Agenda—*Steve Drutz (WA)* — Attachment 3
3. Consider Exposure Proposal 2025-15-CA (A&H Underwriting Risk Structure Change)—*Steve Drutz (WA)* — Attachment 4
4. Request Comments on Conceptual Proposal for Managed Care Credit —*Steve Drutz (WA)* — Attachment 5
5. Discuss Any Other Matters Brought Before the Working Group —*Steve Drutz (WA)*
6. Adjournment

Draft: 10/14/25

Health Risk-Based Capital (E) Working Group
Virtual Meeting
September 29, 2025

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Sept. 29, 2025. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair (TX); Wanchin Chou (CT); Kyle Collins (FL); Tish Becker (KS); Danielle Smith (MO); Margaret Otto (NE); and Diana Sherman (PA). Also participating was: Tom Botsko (OH).

1. Discussed Comments Received on the Academy's H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health RBC Formula Report

Drutz said the Working Group met Sept. 24 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the results of the analysis of the factors and structure presented in the American Academy of Actuaries' (Academy's) report.

Drutz said the Academy's report was exposed during the Working Group's April 30 meeting, with the comment period ending on June 30. The report was available on the Working Group's web page. The Working Group received three comment letters: one from AHIP, one from the Blue Cross Blue Shield Association (BCBSA), and one from UnitedHealth Group (UHG).

Raymond Nelson (AHIP) said that AHIP was supportive of adding the additional product line columns to align with the annual statement analysis of operations, and that the premium break points had not been changed for many years, but the combination could be problematic for some companies. For example, if a company writes $100 million in group premium and $100 million in individual premium, under the current scheme, the first $25 million would have the high factor and the remaining $175 million would have a lower factor, while under the Academy's proposed revisions, all $200 million would be subject to the higher factor.

Nelson then discussed AHIP's concerns with the factor development, as the data used did not include companies that filed the blue blank, and also that the data set includes both the Affordable Care Act (ACA) implementation and the COVID years. AHIP is also concerned that the changes proposed were conservative and that a lower risk percentile may be needed. AHIP also supports the redesign of the Managed Care Credit but emphasized the need for clear instructions for reporting consistency between companies.

Drutz asked the Academy if combining lines of business for the flat alternate risk charge or reducing the flat alternate risk charge for the lines of business as described in the comment letter would impact the Academy's conclusions. Derek Skoog (Academy) believed the changes would have little impact on the factors but would matter to the issuers that are utilizing the alternate risk charge. Steve Guzski (Academy) agreed with Skoog on the possible impact.

Drutz said that the health data in the blue blank has recently changed to align with the formatting and structure found in the orange Blank and would be used in future factor analysis, as the data was not available for the current analysis. Nelson agreed, adding that while the historical blue blank data was not available, the current blue blank data should be included as soon as is feasible.

Drutz addressed the comment in the letter regarding stop loss, saying that the process to update stop loss would likely take time, and updating the underwriting factors can be done independently of any changes to stop loss.

Drutz asked Nelson to expand on the volatility of the data from the ACA and COVID years compared to the volatility in the current health markets, and if certain years would be a better data set. Nelson was not sure if there would be a best set of years to use for data and was more concerned about the impact. During the COVID-19 pandemic, there were years of under-utilization and years of over-utilization, and he asked what the results would be if 2023 and 2024 annual data were added to the analysis. Drutz asked the Academy if the data was used on a yearly basis or aggregated, and if the Academy noticed any differences year to year.

Guzski said the Academy's view was to use a large swath of data, 2012 through 2021, and analyze it on different bases, including one-year, two-year, and five-year chunks. He said that the goal of the analysis was to be as unbiased as possible while providing factors for the NAIC and interested parties to utilize. He also said that those interested in the data trends review Appendix 2b of the report for detailed statistics of loss ratios.

Drutz asked what AHIP meant when discussing a lower risk percentile, as the report had factors at an 87.5% risk percentile. Nelson said that before seeing any impact analysis, the 87.5% risk percentile may be more appropriate when considering the other conservatism in the report, and that maybe the percentile should be lower than 87.5% after AHIP has time to consider the impact analysis.

Chou said that the Society of Actuaries (SOA), when developing the mortality tables for the Life Actuarial (A) Task Force, the data for the COVID years were separated and analyzed to help determine what the possible impact of the event could be. He also encouraged the Academy to consider adding the annual data through 2024 and performing the analysis to include more current data and review the risk percentiles. Chou also said that he would rather take time to consider the appropriate factors to not disrupt the industry. Drutz said the implementation is something the Working Group would need to discuss, as large changes in risk factors have historically been spread over a period of years, and if the Working Group does implement the factors over a period of years, analysis can still be done on the factors.

Carl Labus (BCBSA) said that the BCBSA looks forward to working with the Academy and Working Group on the implementation of recommendations from the report. Labus said its comment letter supports the structural change to show the lines of business at a more granular level and supports review of a possible diversification credit. The letter also supported the review of the Managed Care Credit, as the underwriting risk had not been reviewed for some time. Labus also said the BCBSA supports including blue blank data, as many companies that report on the blue blank were single-state mutuals or not-for-profit companies. The BCBSA also supports a lower risk percentile for factors and supports a phase-in of factors over an extended period when factors are determined.

Jim Braue (UHG) said that its comment letter expressed concern about utilizing the 95% risk percentile factors, and the Academy report acknowledged that the current factors, while developed at the 95% risk percentile, used a different methodology. Braue also referenced the impact analysis included in the meeting materials, noting that the 95% risk percentile would require a substantial increase in capital requirements at any time horizon, causing many companies to fall into the severe risk-based capital (RBC) action levels, and UHG does not believe the current market justifies that.

He also noted that the separation of lines of business and applying the factors independently would be more conservative than the factors as originally developed. The appendix to the Academy's report shows significant variation over the various time periods and said the exclusion of blue blank data, even if unavoidable for this

analysis, could have a substantial impact on the results. UHG generally agrees with the expansion of the Managed Care Credit, noting that the descriptions need to be specific and that the letter lists some concerns with the ability to obtain data. UHG also would like to see the information collected on a line-of-business basis, and the data analysis should determine how the different payment methods are grouped. He asked the Academy to provide clarity on whether the net of reinsurance includes ceded and assumed reinsurance.

Braue said that UHG would like to see the Medicaid factor use a revenue threshold and have two tiers of factors instead of eliminating the tiers and having a single factor. UHG would also like a line added to the structure to show the investment income adjustment, separate from the factors.

Drutz asked the Academy if tiering the Medicaid risk factors would be possible. Skoog responded that he would need to confirm with other members of the Academy working group, but tiering the Medicaid risk factors seemed feasible.

Chou asked the Academy if, upon revisiting the analysis, it could include blank data. Skoog believed that with the changes to the blue blank reporting matching the orange blank reporting line for line, the data could be included in future analysis.

Drutz thanked the commentators, adding that the comments and discussion are very helpful to the Working Group, and that the discussion will continue in future calls.

2. Discussed the Impact Analysis of the Factors and Structure from the Academy's H2 Report

Drutz said the analysis was performed at the cocode level and used a flat alternate risk charge assumption of $500,000 for the lines that made up the comprehensive medical, which were Comprehensive Individual, Comprehensive Group, Title XVIII Medicare, and Title XIX Medicaid. The analysis also used $50,000 as the flat alternate risk charge for the vision-only and dental-only lines.

Derek Noe (NAIC) said that the charts provided show a comparison of the action levels between the 2024 RBC filings and the recalculation under the Academy structure and rate change recommendations. The far right column showed the total for the original filings at each action level, and the bottom row of each chart showed the total for the Academy rate and structure scenario. Noe said that for the structure-only scenario, four companies have improved RBC action levels, and six companies have detrimental RBC action level movement. He said the movement for the 95% risk percentile factors, as noted earlier, was larger than the 87.5% risk percentile factors.

Noe said that when looking at the 95% risk percentile one-year time horizon analysis, 1,105 companies had no action level in their 2024 RBC filings. However, when recalculated with the Academy-provided risk factors and structure change, that number decreased to 780 companies. Drutz added that those companies that moved would be around 25% of the health RBC filers.

Chou said that when comparing the 87.5% risk percentile factors to the 95% risk percentile factors, the 95% risk percentile factors have a couple hundred more companies that move from no action level to an action level compared to the 87.5% risk percentile factors. Drutz said that the previous factors were developed at the 95% risk percentile using a different method, making a direct comparison difficult. He also noted that the property/casualty (P/C) factors are developed at 87.5% risk percentile. Botsko confirmed that the Academy, when developing premium and reserve factors for the P/C RBC formula, used many risk percentiles in the analysis, and the 87.5% risk percentile was adopted by the Working Group.

Drutz asked if the Working Group had any concerns with developing the structure proposal separately while continuing to discuss the factors. Chou said he agreed with the approach, noting that all three comment letters supported the structure change, while the risk factor impact was large and the factors were developed with older data.

Drutz directed NAIC staff to develop a structure proposal that incorporates the separation of lines of business and includes an independent line for the investment income adjustment.

3. Exposed a Referral from the Risk-Based Capital Investment Risk and Evaluation (E) Working Group

Drutz said the referral on Securities Valuation Office (SVO)-designated bond funds sent by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group includes the American Council of Life Insurers (ACLI) presentation on bond fund principles, comment letters received on the presentation, and the exposed proposal 2025-12-IRE, which was drafted for the life formula only. The referral asks the Health Risk-Based Capital (E) Working Group to consider the applicability of the alignment of bond fund implementation in the health RBC formula.

Drutz asked staff to explain the missing structure in the health RBC formula. Maggie Chang (NAIC) said that the health and P/C RBC formulas are missing the structure for both the public registered bond funds and the private bond funds. The scope of the referral was to consider whether public registered bond funds should be included and whether private bond funds should be included. Drutz asked if the public and private funds would require separate changes to the health RBC Blanks. Chang said that the health blanks would need to change so the funds could be separated by the NAIC designation granted by the SVO and given separate factors. Drutz emphasized that commentators should consider the need for changes to the health RBC structure as they are providing comments, and the impacts the changes to the structure could have on the commentator's internal RBC process.

Drutz proposed exposing the referral for a 30-day comment period ending Oct. 29. Chou said that since the Working Group would have to add new structures to the health RBC formula if the exposure period could be extended to 60 days. Drutz asked staff if there were concerns with extending the comment deadline. Noe advised having a comment deadline of Dec. 3 to avoid Thanksgiving. The Working Group agreed and exposed the referral with a comment period ending Dec. 3.

4. Discussed Other Matters

Drutz said that the Health Risk-Based Capital (E) Working Group plans to meet in early November to adopt minutes, adopt the working agenda, and expose the structure proposal. He also said the Working Group will not be meeting in person at the Fall National Meeting.

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

SharePoint/NAIC Support Staff Hub/Committees/ …

Draft: 6/27/25

Health Risk-Based Capital (E) Working Group
Virtual Meeting
June 20, 2025

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met June 20, 2025. The following Task Force members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair (TX); Wanchin Chou (CT); Kyle Colins (FL); Tish Becker (KS); William Leung (MO); and Margaret Garrison (NE).

1. Adopted its April 30 and Spring National Meeting Minutes

The Working Group met April 30 and took the following action: 1) discussed the referral regarding *Interpretation (INT) 24-01: Principles-Based Bond Definition Implementation Questions and Answers*; 2) discussed the referral regarding *INT 24-02: Medicare Part D Prescription Payment Plan*; 3) referred proposal 2025-03-CA to the Capital Adequacy (E) Task Force; and 4) exposed the American Academy of Actuaries (Academy) H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital (RBC) Formula Report.

Chou made a motion, seconded by Leung, to adopt the Working Group's April 30 (Attachment XX) and March 24 (*see NAIC Proceedings – Spring 2025, Capital Adequacy (E) Task Force, Attachment Two*) minutes. The motion passed unanimously.

2. Discussed the 2024 Health RBC Statistics

Drutz said the 2024 health RBC statistics were run on June 3 (Attachment XX). He said 1,143 health RBC filings were loaded onto the NAIC database, down from 1,146 in 2023. Twenty-one companies triggered an action level in 2024, of which eight were at a company action level, two were at a regulatory action level, seven were at an authorized control level (ACL), and four were at a mandatory control level. Drutz said eighteen companies triggered the trend test, and the ACL and total adjusted control (TAC) increased from 2023 to 2024. Drutz asked if there were any objections to posting the statistics to the Working Group's web page. Hearing none, he directed NAIC staff to post the statistics.

3. Discussed Other Matters

Drutz said that an interested party asked if the exposure of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the health RBC formula report could be extended to June 30. Hearing no objections, the Working Group extended the exposure to June 30.

Drutz reminded attendees that the Health Risk-Based Capital (E) Working Group will not meet at the Summer National Meeting.

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

SharePoint/NAIC SharePoint/NAIC Support Staff Hub/ Member Meetings/E Cmte/CADTF/2025-2Summer/HRBC/HRBC_Minutes_06_20_25_TPRd.docx

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

CAPITAL ADEQUACY (E) TASK FORCE
WORKING AGENDA ITEMS FOR CALENDAR YEAR 2026

2026 #	Owner	2026 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – Health RBC							
X1	Health RBC WG	Yearly	Yearly	Evaluate the yield of the 6-month U.S. Treasury Bond as of Jan. 1 each year to determine if further modification to the Comprehensive Medical, Medicare Supplement and Dental and Vision underwriting risk factors is required. Any adjustments will be rounded up to the nearest 0.5%.	HRBCWG	Adopted 2025~~4~~-0~~3~~9-CA (YE-2025~~4~~)	11/4/2021
X2	Health RBC WG	3	Ongoing	Continue to monitor the Federal Health Care Law or any other development of federal level programs and actions (e.g., state reinsurance programs, association health plans, mandated benefits, and cross-border) for future changes that may have an impact on the Health RBC Formula.	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 because of ongoing federal discussions and legislation. Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
Carryover Items Currently being Addressed – Health RBC							
X3	Health RBC WG	2	Year-End 2026~~5~~ 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 Adopted proposal 2023-01-CA	

~~X4~~	~~Health RBC WG~~	~~1~~	~~Year-end 2025 RBC 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.~~ ~~Review the Managed Care Credit calculation in the health RBC formula - specifically Category 2a and 2b.~~ ~~Review Managed Care Credit across formulas.~~ ~~As part of the H2 - Underwriting Risk review, determine if other lines of business should include investment income and how investment income would be incorporated into the existing lines if there are changes to the structure.~~	~~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.~~	~~4/23/2021~~ ~~12/3/2018~~
X4	Health RBC WG	1	Year-End 2026 or later	Change the Structure of page XR013, PR020, and LR020 to align with the lines of business found on Page 7 Analysis of Operations. Add separate line to separate the Investment Income Adjustment from the factors	HRBCWG	Separation of H-2 Underwriting Review	9/29/2025
X5	Health RBC WG	1	Year-End 2026 or later	Expand Exhibit 7 to include new modes of Managed Care Business Expand to collect data by line of business found on Page 7 Analysis of Operations	HRBCWG	Separation of H-2 Underwriting Review	9/29/2025
X6	Health RBC WG	1	Year-End 2027 or later	Develop implementation of updated factors for pages XR013, PR020, and LR020	HRBCWG	Separation of H-2 Underwriting Review	9/29/2025
X~~75~~	Health RBC WG	3	Year-End 202~~65~~ or later	Discuss and determine the re-evaluation of 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. Proposal 2021-09-H - Adopted 5/25/21 by the WG	9/11/2020
New Items – Health RBC							
X8	Health RBC WG	2	Year-End 2027 or later	Discuss incorporating designations for non-bond debt on schedule BA resulting from the adoption of the principle based bond definition.	Referral from SAP WG	WG will review 2025 filings to determine prevalence	4/30/2025
X9	Health RBC WG	2	Year-End 2028 or later	Analyze long-term care insurance (LTCI) underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time.	HRBCWG		4/30/2025

Capital Adequacy (E) Task Force
RBC Proposal Form

☐ Capital Adequacy (E) Task Force ☒ Health RBC (E) Working Group ☐ Life RBC (E) Working Group
☐ Catastrophe Risk (E) Subgroup ☐ P/C RBC (E) Working Group ☐ Longevity Risk (A/E) Subgroup
☐ Variable Annuities Capital. & Reserve (E/A) Subgroup ☐ Economic Scenarios (E/A) Subgroup ☐ RBC Investment Risk & Evaluation (E) Working Group

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

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

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

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

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

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

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

Additional Staff Comments:

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

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

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

UNDERWRITING RISK

Experience Fluctuation Risk

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

Alternate Risk Charge**									
Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement	Vision	Dental	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$500,000	$500,000	$500,000	$500,000	$50,000	$50,000	$50,000	$150,000	$50,000	N/A

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

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

* **This row uses the factors calculated on page XR018**

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

Confidential when Completed

† Annual Statement Source

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

Denotes items that must be manually entered on filing software.

XR013 Formulas

Cell Label	Formula
A1	=Line 12 x {Min[Line (4) x Line (10), 25,000,000 x Line (1)] + Max[0, (Line (4) - 25,000,000) x Line (11)] } / Line (4)
A2	=Line 12 x {Min[Line (4) x Line (10), 3,000,000 x Line (1)] + Max[0, (Line (4) - 3,000,000) x Line (11)] } / Line (4)
B1	=Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)]
B2	=Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)]
B3	=Max[0, 150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(18) - C(7) L(18)]
B4	=Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(18) - C(7) L(18) - C(8) L(18)]

Confidential when Completed

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

Denotes items that must be manually entered on filing software.

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

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

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

* The factor applies to all Noncanellable premium.

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

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

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

Denotes items that must be manually entered on filing software.

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Limited Benefit Plans (Individual and Group Combined)		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
(41)	Hospital Indemnity and Specified Disease	Included in Page 7, Column 13, Line 1 and 2, in part		0.035	
(41.1)	$50,000 if Line (42) is Greater Than Zero				
(41.2)	Total Hospital Indemnity and Specified Disease	Lines (41) + (41.1)			
(42)	Accidental Death & Dismemberment	Included in Page 7, Column 13, Line 1 and 2, in part			
(42.1)	First $10 Million Earned Premium of Line (43)			0.055	
(42.2)	Over $10 Million Earned Premium of Line (43)			0.015	
(42.3)	Maximum Retained Risk for Any Single Claim	Company Records			
(42.4)	Three Times Line (43.3)				
(42.5)	Lesser of Line (43.4) or $300,000				
(42.6)	Total AD&D	Lines (42.1) + (42.2) + (42.5)			
(43)	Other Accident	Included in Page 7, Column 13, Line 1 and 2, in part		0.050	
(44)	Premium Stabilization Reserves	Included in U&I, Part 2D, Column 1, Line 4		-0.500 Φ	
(45)	Total Other Underwriting Risk	Lines (24.3) + (25.3) + (26.3) + (27.3) + (28.3) + (29.6) + (30.3) + (31.3) + (40) + (41.2) + (42.6) + (43) + (44)			

Φ This is limited to the Total Net Underwriting RBC on XR013, Column (11), Line (21) Less Column (8), and XR015, Column (2), Lines (24.3), (25.3), (26.3), (27.3), (28.3), (29.6), (30.3), (31.3), XR016 Column (2), Line (35) and XR017 Column (2), Lines (41.2), (42.6), and (43).

Denotes items that must be manually entered on filing software.

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BUSINESS RISK

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

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

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

Denotes items that must be manually entered on filing software.

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

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CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

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

Denotes items that must be manually entered on filing software.

HEALTH PREMIUMS

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

† The premium amounts in these lines are transferred to LR020 Underwriting Risk – Experience Fluctuation Risk Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete LR022 Underwriting Risk – Managed Care Credit. In which case, the company will also need to complete LR028 Health Credit Risk in the (C-3) portion of the formula. If there are amounts in any of lines (1) through (7), (13) through (17), or (19) and (20) on page LR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of LR029 Business Risk in the (C-4) portion of the formula.

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

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

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

** The factor applies to all Noncancellable premium.

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

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

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

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UNDERWRITING RISK

Experience Fluctuation Risk

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

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

	Initial Premium Amount‡				
	Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement
	$500,000	$500,000	$500,000	$500,000	$50,000

* The Line (16) Alternate Risk Charge is calculated as follows:

	Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement
	$500,000	$500,000	$500,000	$500,000	$50,000

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

† Annual Statement Source

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

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

LR020 Formulas

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

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HEALTH CLAIMS RESERVES

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

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

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

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PREMIUM STABILIZATION RESERVES

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

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BUSINESS RISK

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

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

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

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BUSINESS RISK (CONTINUED)

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

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

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Company Name | Confidential when Completed | NAIC Company Code

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

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

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Company Name | Confidential when Completed | NAIC Company Code

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

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

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

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

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

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

† Denotes lines that are deducted from the total rather than added.

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

Company Name | Confidential when Completed | NAIC Company Code

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

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

† Denotes lines that are deducted from the total rather than added.

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

HEALTH PREMIUMS PR019

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

† The premium amounts in these lines are transferred to PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement, Dental & Vision and Stand-Alone Medicare Part D Coverage Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete PR021 Underwriting Risk – Managed Care Credit. In which case, the company will also need to complete PR012 Health Credit Risk in the formula. If there are amounts in any of lines (1), (2), (3), (7), (8) or (10) on page PR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of PR023.

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

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

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

** The factor applies to all Noncancellable premium.

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

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

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

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

(Experience Fluctuation Risk in Life RBC Formula)

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

† Source is company records unless already included in premiums.

Initial Premium Amount‡					
	Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement
	$25,000,000	$25,000,000	$25,000,000	$25,000,000	$3,000,000

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

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

Alternate Risk Charge*					
	Comprehensive (Hospital & Medical) - Individual	Comprehensive (Hospital & Medical) - Group	Title XVIII - Medicare	Title XIX - Medicaid	Medicare Supplement
	$500,000	$500,000	$500,000	$500,000	$50,000

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

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

PR020 Formulas

Cell Label	Formula
A1	=Line 12 x {Min[Line (4) x Line (10), 25,000,000 x Line (1)] + Max[0, (Line
A2	=Line 12 x {Min[Line (4) x Line (10), 3,000,000 x Line (1)] + Max[0, (Line (
B1	=Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)]
B2	=Max[0, 50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(1
B3	=Max[0, 150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(

(4) - 25,000,000) x Line (11)] } / Line (4)
4) - 3,000,000) x Line (11)] } / Line (4)

UNDERWRITING RISK - OTHER AND TOTAL NET HEALTH PREMIUM RBC PR022

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

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

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

PREMIUM STABILIZATION RESERVES PR025

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

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

UNDERWRITING RISK - L(1) THROUGH L(201)

XR013

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

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

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

Claims Experience Fluctuation

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

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

or

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

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using the health organization's actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports, the RBC results for all of the formula components shall be calculated using actual data.

L(1) through L(201)

There are tensix lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive (Hospital & Medical) individual & group; (2) Comprehensive (Hospital & Medical) group; (3) Title XVIII Medicare; (4) Title XIX Medicaid; (52) Medicare Supplement; (63) Dental/Vision; (7) Dental; (84) Stand-Alone Medicare Part D Coverage; (95) Other Health; and (106) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

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

Column (2) – Comprehensive (Hospital & Medical) Group Includes policies providing for medical coverages including hospital, surgical, and major medical. Prescription drug benefits included in major medical insurance plans should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Column (3) – Title XVIII Medicare Business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans

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

Column (52) – Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under Comprehensive (Hospital & Medical) Individual & Group. under Title XVIII Medicare.

Column (63) – Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

Column (7) – Dental This is limited to policies providing for dental-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

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

Column (9~~5~~) – Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, that have not been specifically addressed in Columns (1) through (8~~4~~) listed above and those lines of business addressed separately on page XR015, such as stop loss. Stop-loss premiums are addressed separately in Line (25) on page XR015.

Column (10~~6~~) – Other Non-Health Coverages. This includes life and property and casualty coverages.

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

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

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

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

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

Line (2~~4~~) Other Health Risk Revenue. This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.

Line (3~~5~~) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

Line (4~~6~~) Underwriting Risk Revenue. The sum of Lines (1) ~~through~~ and (2~~4~~) minus Line (3~~5~~).

Line (5~~7~~) Net Incurred Claims. Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or Federal Employees Health Benefits Program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR015.

Line (6~~8~~) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

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

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

Line (8~~11~~) Underwriting Risk Incurred Claims. Line (5~~9~~) minus Lines (6~~10~~) and (7).

Line (9~~12~~) Underwriting Risk Claims Ratio. For Columns (1) through (9~~5~~), Line (8~~11~~)/Line (4~~6~~). If either Line (4~~6~~) or Line (8~~11~~) is zero or negative, Line (9~~12~~) is zero.

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

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

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

Line (13) Composite Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (4~~6~~), Underwriting Risk Revenue. The factors for Column (1) through (7~~3~~) have incorporated an investment income yield of 4.5%.

	$0 – $3 Million	$3 – $25 Million	Over $25 Million
Comprehensive (Hospital & Medical) Individual & Group	0.1440	0.1440	0.0844
Medicare Supplement	0.0987	0.0609	0.0609
Dental & Vision	0.1153	0.0716	0.0716
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

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

Line (14) Base Underwriting Risk RBC. Line (46) x Line (912) x Line (13).

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

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

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

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

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

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

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

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

Examples of the calculation are presented below:

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

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

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

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

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

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

Line (17~~8~~) Alternate Risk Charge. ~~This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation~~. $500,000 for Columns (1), (2), (3), and (4); $50,000 for Columns (5), (6), (7), and (9); and $150,000 for Column (8).

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

Line (18~~20~~) Net Alternate Risk Charge. ~~This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.~~ Columns (1), (2), (3), and (4) equal to Line (17); Column (5) is Max[0, $50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)]; Columns (6) and (7) are Max[0, $50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)]; and Column (8) is Max[0, $150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(18) - C(7) L(18)]

Line (~~21~~19) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (18~~20~~) for each of columns (1) through (9~~5~~). This is the amount in Line (14), Column (~~6~~10). The amount in Column (11~~7~~) is the sum of the values in Columns (1) through (10~~6~~).

OTHER UNDERWRITING RISK – L(20~~2~~) THROUGH L(44~~5~~)

XR015–XR017

In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when reporting entities guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for

those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e., Comprehensive (Hospital & Medical) individual & group, Medicare Supplement, Dental/Vision, Stand-Alone Medicare Part D Coverage, Supplemental benefits within Medicare Part D Coverage, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

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

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

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

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

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

STOP-LOSS ELECTRONIC-ONLY TABLES

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

Electronic Table 1 – Stop-Loss Interrogatories

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

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

The categories used in the interrogatories are separated as follows:

Product Type

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

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

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

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

Total Gross Claims + Expenses =

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

+

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

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

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

Total Net Claims + Expenses =

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

+

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HEALTH PREMIUMS and HEALTH CLAIMS RESERVES

LR019, LR023 and LR024

Basis of Factors

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

Medical Insurance Premium

The business is subdivided by product into categories for individual coverages and for group and credit coverages depending on the risk related to volatility of claims. The factors were developed from a model that determines the minimum amount of surplus needed to protect the company against a worst-case scenario for each type of coverage. The results of the model were then translated into either a uniform percentage or a two-tier formula to be applied to premium. The two-tier formula reflects the decreased risk of a larger in-force block. The formula includes several changes starting in 1998 for some types of health insurance. These changes add several worksheets and are designed to keep the RBC amounts for health coverage consistent regardless of the RBC formula used. If the company has comprehensive medical business **(Individual & Group), Title XVIII Medicare, Title XIX Medicaid,** medicare supplement, **vision,** dental business, or Stand-Alone Medicare Part D coverage through a PDP arrangement, it will be directed to these additional worksheets. The instructions for including paid health claims in the various categories of the Managed Care Discount Factor Calculation can be found in the instructions to LR022 Underwriting Risk – Managed Care Credit. Appendix 3~~2~~ of these instructions list~~s~~ commonly used health insurance terms. Appendix 4~~3~~ of these instructions ~~lists~~list commonly used terms specific to Stand-Alone Medicare Part D coverage. If the company has any of the ~~four~~ mentioned types of medical insurance, it will also be required to complete additional parts of the formula for C-3 Health Credit Risk and C-4 Health Administrative Expenses Risk portion of the Business Risk.

Disability Income Premium

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

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

Long-Term Care Insurance Premium

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

Claim Reserves

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

Pre-Tax and Post-Tax Factors

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

Specific Instructions for Application of the Formula

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

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

Line (1)

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

Line (2)

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

Line (3)

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

Line (4~~2~~)

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

Line (5~~3~~)

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

Line (~~5~~6)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line (282)	Other Disability Income - Individual Morbidity	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (282) [up to $50 million less premium in a) of Line (271)]	Company Records		X 0.3168 =	
b)	Earned Premium in Line (282) not included in a) of Line (282)	Company Records		X 0.0889 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (282) + b) of Line (282), Column (2)			
Line (293)	Disability Income - Credit Monthly Balance	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	First $50 Million Earned Premium of Line (293)	Company Records		X 0.2534 =	
b)	Over $50 Million Earned Premium of Line (293)	Company Records		X 0.0378 =	
c)	Total Disability Income - Credit Monthly Balance	a) of Line (293) + b) of Line (293), Column (2)			
Line (3024)	Disability Income – Group Long-Term	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (3024) [up to $50 million less premium in a) of Line (293)]	Company Records		X 0.1901 =	
b)	Earned Premium in Line (3024) not included in a) of Line (3024)	Company Records		X 0.0378 =	
c)	Total Disability Income – Group Long-Term	a) of Line (3024) + b) of Line (3024), Column (2)			
Line (3125)	Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part. This amount to be reported on LR019 Health Premiums, Line (3125)			
a)	Additional Reserves for Credit Disability Plans	LR019 Health Premiums Column (1) Line (4234)			
b)	Additional Reserves for Credit Disability Plans, Prior Year	LR019 Health Premiums Column (1) Line (4335)			
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (3125) - a) of Line (3125) + b) of Line (3125)			
d)	Earned Premium in c) [up to $50 million less premium in a) of Line (293) + a) of Line (3024)]	Company Records		X 0.1901 =	
e)	Earned Premium in c) of Line (3125) not included in d) of Line (3125)	Company Records		X 0.0378 =	
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (3125) + e) of Line (3125), Column (2)			

Line (3226)	Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (3226) [up to $50 million less premium in a) of Line (293) + a) of Line (3024) + d) of Line (3125)]	Company Records		X 0.1267 =	
b)	Earned Premium in Line (3126) not included in a) of Line (3126)	Company Records		X 0.0378 =	
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (3226) + b) of Line (3226), Column (2)			
Line (3327)	Disability Income – Group Short-Term	Earned Premium included in Health Supplement Analysis of Operations Column 11, Line 1 + 2, ~~Schedule H, Part 1, Line 2,~~ in part			
a)	Earned Premium in Line (3327) [up to $50 million less premium in a) of Line (293) + a) of Line (3024) + d) of Line (3125) + a) of Line (3226)]	Company Records		X 0.0634 =	
b)	Earned Premium in Line (3327) not included in a) of Line (3327)	Company Records		X 0.0378 =	
c)	Total Disability Income – Group Short-Term	a) of Line (3327) + b) of Line (3327), Column (2)			

Lines (3528) and (3629)

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

Line (391)

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

Line (4032)

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

Stop Loss Electronic Only Tables

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

Electronic Table 1 – Stop Loss Interrogatories

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

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

The categories used in the interrogatories are separated as follows:

Product Type

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

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

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

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

Total Gross Claims + Expenses =

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

+

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

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

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

Total Net Claims + Expenses =

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

+

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =

(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

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

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

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

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

UNDERWRITING RISK – EXPERIENCE FLUCTUATION RISK

LR020

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

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

There are other arrangements where the insurer is not at risk for excessive claims payments, such as when an insurer agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claims costs, so the risk of excessive claims experience is borne by the self-insured employer, not the insurer. The underwriting risk section of the RBC formula, therefore, requires some adjustments to remove non-risk business (premiums and claims) before the RBC requirement is calculated.

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

Claims Experience Fluctuation

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

A. Underwriting risk revenue times the underwriting risk claims ratio times a set of factors.

or

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

Line (1) through Line (198)

There are eight~~four~~ lines of business used in the life and fraternal RBC formula for calculating the RBC requirement in this worksheet. Other health coverages will continue to use the factors on LR019 Health Premiums. The ~~four~~ eight lines of business are: Column (1) Comprehensive Medical and Hospital - Individual; Column (2) Comprehensive Medical and Hospital - Group; Column (3) Title XVIII Medicare; Column (4) Title XIX Medicaid; Column (52) Medicare Supplement; Column (63) ~~Dental &~~ Vision Only; Column (7) Dental Only; and Column (84) Stand-Alone Medicare Part D coverage. Each of the ~~four~~ eight lines of business has its own column in the Underwriting Risk - Experience Fluctuation Risk table. The categories listed in the columns of this worksheet include premiums plus all risk revenue that is received from another reporting entity in exchange for medical services provided to its members.

For details of each category refer to LR019 instructions.

~~The descriptions of the items are as follows:~~

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

~~Medical Only (non-hospital professional services)~~
~~Include in Comprehensive Medical.~~

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

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

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

~~Other Health Coverages~~
~~Include in the appropriate line on LR019 Health Premiums.~~

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

Line (1) Premium
This is the amount of money charged by the insurer for the specified benefit plan. It is the earned premium, net of reinsurance. It does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-risk business; or premium for the Federal Employees Health Benefit Programs (FEHBP), which has a risk factor relating to incurred claims reported separately under LR021 Underwriting Risk – Other, Line (3).

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

For Stand-Alone Medicare Part D Coverage, this will include only certain amounts paid by the individual, an employer or CMS. See Appendix ~~3~~ 4 for details of what is and is not premium income.

~~Line (2) Title XVIII Medicare~~
~~This is the earned amount of money charged by the insurer (net of reinsurance) for Medicare risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans.~~

~~Line (3) Title XIX Medicaid~~
~~This is the earned amount of money charged by the insurer for Medicaid risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicaid subscribers. Revenue from Stand-Alone Medicare Part D coverage under the low-income subsidy (cost sharing portion) and low-income subsidy (premium portion) are not included in this line.~~

Line (~~2~~2) Other Health Risk Revenue
Earned amounts charged by the reporting company as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders or members of another insurer or managed care organization (MCO). Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or MCO to the company in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the company from another reporting entity. This revenue is reported in the business risk section of the formula as health ASO/ASC and limited risk revenue.

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

Line (~~4~~5) Underwriting Risk Revenue
~~The sum of~~ Lines (1.3) ~~through~~ + (~~2~~4)~~ – (3)~~.

Line (~~5~~6) Net Incurred Claims
Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the insurer. Paid claims includes capitation and all other payments to providers for services to covered lives, as well as reimbursement directly to insureds (or their providers) for covered services. Paid claims also include salaries paid to company employees that provide medical services to covered lives and related expenses. Line (~~5~~6) does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

~~Column (1) claims come from Schedule H, Part 5, Columns 1 and 2 Line 13 less the amounts reported as incurred claims for administrative services contracts (ASC) in Line (54) of LR029 Business Risk and Federal Employee Health Benefit Program (FEHBP) in Line (3) of LR021 Underwriting Risk – Other. Column (2) for Medicare supplement should be net of reinsurance, the same as the other columns. Column (2) for Medicare supplement should use the direct claims from General Interrogatories Part 2, Line 1.5 after adjusting them for reinsurance. Column (3) dental claims come from Schedule H, Part 5, Column 5, Line 13.~~

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix ~~3~~4). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim liabilities should reflect expected recoveries from the reinsurance coverage – for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS.

Line (6) Medicaid Pass-Through Payments Reported as Claims.
Medicaid Pass-Through Payments that are included as claims.

Line (7) Fee-for-Service Offset
Report fee-for-service revenue that is directly related to medical expense payments. The fee-for-service line does not include revenue where there is no associated claim payment (e.g.,

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

Line (8) Underwriting Risk Incurred Claims
Lines (5~~6~~) – ~~minus Line~~ (6~~7~~) – (7).

Line (9) Underwriting Risk Claims Ratio
Line (8) / Line (4~~5~~). If either Line (4~~5~~) or Line (8) is zero or negative, Line (9) is zero.

Line (10) ~~Underwriting Risk Factor~~Underwriting Risk Factors for Initial Amounts of Premium
Factor applied to the first $25,000,000 in premium for columns (1), (2), (3), (4), and (8) and applied to the first $3,000,000 in premium for columns (5), (6), (7).
~~A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.~~

	~~$0 - $3 Million~~	~~$3 - $25 Million~~	~~Over $25 Million~~
~~Comprehensive Medical~~	~~0.14341440~~	~~0.14341440~~	~~0.08380844~~
~~Medicare Supplement~~	~~0.09800987~~	~~0.06030609~~	~~0.06030609~~
~~Dental~~	~~0.11481153~~	~~0.07110716~~	~~0.07110716~~
~~Stand-Alone Medicare Part D Coverage~~	~~0.251~~	~~0.251~~	~~0.151~~

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

Line (12) Income Adjustment Factor

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

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

Line (15~~2~~) Managed Care Discount
For Comprehensive Medical & Hospital Individual, Comprehensive Medical & Hospital Group, Title XVIII Medicare, Title XIX Medicaid, Medicare Supplement (including Medicare Select), Vision, and Dental, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claims payments attributable to the managed care arrangements. The discount factor is from Column (3) Line (17) of LR022 Underwriting Risk – Managed Care Credit. An average factor based on the combined results of these ~~three~~ categories is used ~~for all three~~.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of LR022 Underwriting Risk – Managed Care Credit.

Line (16~~3~~) Base RBC After Managed Care Discount
Line (14~~1~~) x Line (15~~2~~).

Line (14) RBC Adjustment for Individual

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

Line (15) Maximum Per-Individual Risk After Reinsurance

This is the maximum loss after reinsurance for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under non-proportional reinsurance or stop-loss protection with the highest attachment point is capped at less than $750,000 per insured for comprehensive medical and $25,000 for the other three lines, the maximum retained loss will be equal to such attachment point plus the difference between the coverage maximum per claim and $750,000 or $25,000, whichever is applicable.

- Where the non-proportional reinsurance or stop-loss protection is subject to participation by the company, the maximum retained risk as calculated above will be increased by the company's participation in claims in excess of the attachment point, but not to exceed $750,000 for comprehensive medical and $25,000 for the other three coverages.

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

Examples of the calculation are presented below:

EXAMPLE 1 (Insurer provides Comprehensive Care):

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

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

EXAMPLE 2 (Insurer provides Comprehensive Care):

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

Maximum Retained Risk =	$75,000	deductible
	+ 0	($750,000 - $1,075,000)
	+$67,500	(10% of $675,000 coverage layer)
	=$142,500	

Line (176) Alternate Risk Charge

~~Twice the amount in Line (15), subject to a maximum of $1,500,000 for comprehensive medical and $50,000 for Medicare Supplement and Dental. Six times the amount in Line (15), subject to a maximum of $150,000 for Stand-Alone Medicare Part D Coverage~~. $500,000 for Columns (1), (2), (3), and (4); $50,000 for Columns (5), (6), and (7); and $150,000 for Column (8).

Line (187) Net Alternate Risk Charge

~~The largest value from Line (16) is retained for that column in Line (17) and all others are ignored.~~ Columns (1), (2), (3), and (4) equal to Line (17); Column (5) is Max[0, $50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)]; Columns (6) and (7) are Max[0, $50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)]; and Column (8) is Max[0, $150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(18) - C(7) L(18)]

Line (198) Net Underwriting Risk RBC

The maximum of Line (164) and Line (187).

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

If the reporting company writes 5% or more of its premiums in A&H lines in 2023, 2024 or 2025, this section of the formula must be completed. To determine if that applies, take the sum of Lines 13, 14 and 15 of the Underwriting and Investment Exhibit Part 1B Column 6 and divide by Line 35 Column 6, and round to three decimals for each individual year. If the result is at least 0.050 in any year, this exhibit and the appropriate Schedule P adjustment must be completed.

If the company writes less than 5% of its premiums in A&H lines in 2023, 2024 and 2025, disregard this section.

PR019 - Health Premiums

Basis of Factors

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

Medical Insurance Premium

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

Disability Income Premium

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

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

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

Specific Instructions for Application of the Formula

The total of all earned premium categories PR019 Health Premiums, Line (3626), Column (1) should equal the total in ~~Schedule H~~ U&I, Part 1, Line 13.1 through 15.92, Column 41 of the Annual Statement. Earned premium for each of these coverages should be from underlying company records. Earned premium may be reported in ~~Schedule H~~U&I for Administrative Services Contract (ASC) and/or the Federal Employees Health Benefit Program (FEHBP) which are included in order that Line (3626) will equal the total in ~~Schedule H~~U&I. As such, there is no RBC factor applied to any premium reported on lines (2214), (3223) or (3424). For some of the coverages, two tier formulas apply. The calculations for these coverages shown below will not appear on the RBC filing software but will automatically be calculated by the software.

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

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

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

Line (4~~2~~)
Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (5~~2~~) Line (1.1).

Line (5~~3~~)
Health premiums for ~~dental or~~ vision coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (6~~3~~) Line (1.1).

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

Line (7~~3~~.1)
Health premium for Stand-Alone Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (2~~1~~). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (8~~4~~) Line (1.1).

Line (7~~3~~.2)
Health incurred claims for Supplemental benefits within Stand-Alone Medicare Part D coverage written on individual contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible. This does not include the low-income subsidy (cost sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Stand-Alone Medicare Part D Coverage on PR019.

Line (7~~3~~.3)
Medicaid pass-through payments reported as premium ~~and excluded from Line (1) should be reported in Line (3.3)~~.

Line (8~~4~~) and Line (19~~1~~)
There is a factor for certain types of limited benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5%) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (9~~5~~) and Line (20~~12~~)

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

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

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

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

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

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

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

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

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

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

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

Line (180.1)

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

Line (180.2)

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

Line (180.3)

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

Lines (2315) through (3424)

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

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 815) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b), etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

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

		Annual Statement Source	Statement Value	Factor	RBC Requirement
	Disability Income Premium				
Line (27~~19~~)	Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in U&I Part 1, Column 4 Line 15.3~~Schedule H, Part 1, Column 21, Line 2,~~ in part. This amount to be reported on Health Premiums, Line (27~~19~~)			
a)	Additional Reserves for Credit Disability Plans	PR019 Health Premiums Column (1) Line (37~~27~~)			
b)	Additional Reserves for Credit Disability Plans, Prior Year	PR019 Health Premiums Column (1) Line (38~~28~~)			
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (27~~19~~) - a) of Line (27~~19~~) + b) of Line (27~~19~~)			
d)	Earned Premium in c) [up to $50 million less premium in a) of Line (25~~17~~) + a) of Line (26~~18~~)]	Company Records		X 0.100 =	
e)	Earned Premium in c) of Line (27~~19~~) not included in d) of Line (27~~19~~)	Company Records		X 0.030 =	
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (27~~19~~) + e) of Line (27~~19~~), Column (2)			
Line (28~~0~~)	Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in U&I Part 1, Column 4 Line 15.3~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	Earned Premium in Line (28~~0~~) [up to $50 million less premium in a) of Line (25~~17~~) + a) of Line (26~~18~~) + d) of Line (27~~19~~)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (28~~0~~) not included in a) of Line (28~~0~~)	Company Records		X 0.030 =	
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (28~~0~~) + b) of Line (28~~0~~), Column (2)			
Line (29~~1~~)	Disability Income – Group Short Term	Earned Premium included in U&I Part 1, Column 4 Line 15.3~~Schedule H, Part 1, Column 21, Line 2,~~ in part			
a)	Earned Premium in Line (29~~1~~) [up to $50 million less premium in a) of Line (25~~17~~) + a) of Line (26~~18~~) + d) of Line (27~~19~~) + a) of Line (28~~0~~)]	Company Records		X 0.050 =	
b)	Earned Premium in Line (29~~1~~) not included in a) of Line (29~~1~~)	Company Records		X 0.030 =	
c)	Total Disability Income – Group Short Term	a) of Line (29~~1~~) + b) of Line (29~~1~~), Column (2)			
Line (31~~22~~)	Noncancellable Long-Term Care Premium – Rate risk	Earned Premium (U&I Part 1, Column 4 Line 15.7~~Schedule H, Part 1, Column 23, Line 2~~, in part)		X 0.100 =	

Line (~~2~~35)

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

Stop-Loss Electronic-Only Tables

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

Electronic Table 1 – Stop-Loss Interrogatories

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

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

The categories used in the interrogatories are separated as follows:

Product Type

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

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

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

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

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

+

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

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

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

Total Net Claims + Expenses =

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

+

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

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

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

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

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

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

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

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

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

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

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

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

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

= $150,000

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

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

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

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

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

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

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

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

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

The columns are as follows:

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

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

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

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

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

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

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

Column (8) – Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page PR019. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here

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

> Underwriting risk is present when the next dollar of unexpected claims payments comes directly out of the company's capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, an insurer may charge an individual $100 in premium in exchange for a guaranty that all medical costs will be paid by the insurer. If the individual incurs $101 in claims costs, the company's surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.
>
> There are other arrangements where the insurer is not at risk for excessive claims payments, such as when an insurer agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claims costs, so the risk of excessive claims experience is borne by the self-insured employer, not the insurer. The underwriting risk section of the RBC formula, therefore, requires some adjustments to remove non-risk business (both premiums and claims) before the RBC requirement is calculated.

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

Claims Experience Fluctuation

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

A. Underwriting risk revenue times the underwriting risk claims ratio times a set of factors.

or

B. An alternate risk charge that addresses the risk of catastrophic claims on any single individual. The alternate risk charge is calculated for each type of health coverage~~, but only the largest value is compared to the value from A. above for that type~~. ~~The alternate risk charge is equal to a multiple of the maximum retained risk on any single individual in a claims year.~~ ~~The maximum retained risk (level of potential claim exposure) is capped at two times the maximum or $1,500,000 for Comprehensive Medical; two times the maximum or $50,000 for each of Medicare Supplement business and dental coverage and six times the maximum or $1,500,000 for Stand-Alone Medicare Part D coverage.~~ The maximum retained risk (level of potential claim exposure) is $500,000 per line for medical coverage; $50,000 for all other coverage except Medicare Part D coverage and $150,000 for Medicare Part D coverage.

Line (1) through Line (19~~8~~)

There are ~~four~~ eight lines of business used in the property/casualty RBC formula for calculating the RBC requirement in this worksheet. Other health coverages will continue to use the factors on PR019 Health Premiums. The four lines of business are Column (1) Comprehensive Medical ~~and Hospital~~Individual; Column (2) Comprehensive Medical Group; Column (3) Title XVIII Medicare; Column (4) Title XIX Medicaid; Column (5~~2~~) Medicare Supplement; Column (6~~3~~) ~~Dental &~~ Vision; Column (7) Vision; and Column (8~~4~~) Stand-Alone Medicare Part D coverage. Each of the ~~four~~ eight lines of business has its own column in the Underwriting Risk – Premium Risk table. The categories listed in the columns of this worksheet include premiums plus all risk revenue that is received from another health entity in exchange for medical services provided to such Health entity's members. ~~The descriptions of the items are as follows:~~

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

~~Medical Only (non-hospital professional services)~~
~~Include in Comprehensive Medical.~~

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

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

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

~~Other Health Coverages~~
~~Include in the appropriate line on PR019 Health Premiums.~~

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

Line (1) Premium

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

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

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

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

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

~~Line (2) Title XVIII Medicare~~
~~This is the earned amount of money charged by the insurer (net of reinsurance) for Medicare risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans.~~

~~Line (3) Title XIX Medicaid~~
~~This is the earned amount of money charged by the insurer for Medicaid risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicaid subscribers. Revenue from Stand-Alone Medicare Part D coverage under the low-income subsidy (cost sharing portion) and low-income subsidy (premium portion) are not included in this line.~~

Line (2~~4~~) Other Health Risk Revenue
Earned amounts charged by the reporting company as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders or members of another insurer or health insurance company (Health). Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health insurance company to the company in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the company from a health entity. This revenue is reported in the business risk section of the formula as health ASO/ASC and limited risk revenue.

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

Line (4~~5~~) Underwriting Risk Revenue
~~The sum of~~ Line~~s~~ (1~~.3~~)~~-~~+ Lines (2) – Line (3)~~through (4)~~.

Line (5~~6~~) Net Incurred Claims

Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the insurer. Paid claims include capitation and all other payments to providers for services to covered lives, as well as reimbursement directly to insureds (or their providers) for covered services. Paid claims also include salaries paid to company employees that provide medical services to covered lives and related expenses. This line does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

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

~~Column (1) claims come from Annual Statement, Schedule H, Part 5 Column 1+2+7+8 Line D1 less the amounts reported as incurred claims for Administrative Services Contracts (ASC) in Line (8) of PR013 and Federal Employee Health Benefit Plan (FEHBP) in Line (3) of PR022. Column (2) claims come from Schedule H, Part 5, Column 3, Line D1. Column (3) dental and vision claims come from Schedule H, Part 5, Columns 4+5, Line D11.)~~

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix 2). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim liabilities should reflect expected recoveries from the reinsurance coverage – for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS.

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

Line (7) Fee-for-Service Offset
Report fee-for-service revenue that is directly related to medical expense payments. The fee-for-service line does not include revenue where there is no associated claim payment (e.g., fees or charges to nonmember/insured of the company where the provider of the service receives no additional compensation from the company) and when such revenue was excluded from the pricing of medical benefits.

Line (8) Underwriting Risk Incurred Claims
Line (5~~6~~) – Line (6) – ~~minus~~ Line (7).

Line (9) Underwriting Risk Claims Ratio
Line (8) / Line (4~~5~~). If either Line (4~~5~~) or Line (8) is zero or negative, Line (9) is zero.

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

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

Line (12) Income Adjustment Factor

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

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

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

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

Line (15~~2~~) Managed Care Discount
For Comprehensive Medical & Hospital Individual, Comprehensive Medical & Hospital Group, Title XVIII Medicare, Title XIX Medicaid, Medicare Supplement (including Medicare Select), Vision, and Dental, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claims payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (12) of PR021 Underwriting Risk - Managed Care Credit. An average factor based on the combined results of these ~~three~~ categories ~~is used for all three~~.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (12) of PR021 Underwriting Risk - Managed Care Credit.

Line (16~~3~~) Base RBC After Managed Care Discount
Line (14~~1~~) x Line (15~~2~~).

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

~~Line (15) Maximum Per Individual Risk After Reinsurance~~
~~This is the maximum loss after reinsurance for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:~~

- ~~Where coverage under non-proportional reinsurance or stop-loss protection with the highest attachment point is capped at less than $750,000 per insured for Comprehensive Medical and $25,000 for the other three lines, the maximum retained loss will be equal to such attachment point plus the difference between the coverage maximum per claim and $750,000 or $25,000, whichever is applicable.~~

- ~~Where the non-proportional reinsurance or stop-loss protection is subject to participation by the company, the maximum retained risk as calculated above will be increased by the company's participation in claims in excess of the attachment point, but not to exceed $750,000 for Comprehensive Medical and $25,000 for the other three coverages.~~

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

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

~~EXAMPLE 1 (Insurer provides Comprehensive Care):~~

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

~~Maximum Retained Risk = $100,000 deductible~~
~~+$150,000 ($750,000 - $600,000)~~
~~+$50,000 (10% of $500,000 coverage layer)~~
~~=$300,000~~

~~EXAMPLE 2 (Insurer provides Comprehensive Care):~~

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

~~Maximum Retained Risk = $75,000 deductible~~
~~+$0 ($750,000 - $1,075,000)~~
~~+$67,500 (10% of $675,000 coverage layer)~~
~~=$142,500~~

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

$500,000 for Columns (1), (2), (3), and (4); $50,000 for Columns (5), (6), and (7); and $150,000 for Column (8).~~Twice the amount in Line (15), subject to a maximum of $1,500,000 for comprehensive medical and $50,000 for Medicare Supplement and Dental. Six times the amount in Line (15), subject to maximum of $150,000 for Stand-Alone Medicare Part D Coverage.~~

Line (18~~7~~) Net Alternate Risk Charge

~~The largest value from Line (16) is retained for that column in line (17) and all others are ignored.~~ Columns (1), (2), (3), and (4) equal to Line (17); Column (5) is Max[0, $50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18)]; Columns (6) and (7) are Max[0, $50,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18)]; and Column (8) is Max[0, $150,000 - C(1) L(18) - C(2) L(18) - C(3) L(18) - C(4) L(18) - C(5) L(18) - C(6) L(18) - C(7) L(18)]

Line (19~~8~~) Net Underwriting Risk RBC

The maximum of Line (164) and Line (187).

ANNUAL STATEMENT INSTRUCTIONS – HEALTH

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

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

This schedule requires disclosure of claim payments by type of managed care arrangement.

Table~~Column~~ 2 – Net Reinsurance Amount

Amount of payment ceded to reinsurance

Table~~Column~~ 3 – Medical Expense Payment (Net of Reinsurance)

Table 1 - 2

Line 7 – Bonus/Withhold Arrangements – Fee-for-Service

Include: Payments to contracting providers that, absent the withhold arrangement or bonus arrangement, would otherwise be reported on Line 5, Fee-for-Service.

Line 7.1 – Bonus Payment Exposure

Include: Include total bonus payments providers were eligible for in the prior year.

Line 7.2 – Bonus Payments Made

Include: Include bonus payments made to these providers in the prior year.

Line 8 – Bonus/Withhold Arrangements – Contractual Fee Payments

Include: Payments to contracting providers that, absent the withhold or bonus arrangement, would otherwise be reported on Line 6.

Line 8.1 – Bonus Payment Exposure

Include: Include total bonus payments providers were eligible for in the prior year.

Line 8.2 – Bonus Payments Made

Include: Include bonus payments made to these providers in the prior year.

Line 9 – Bundled Payments

Include: Fixed payments to contracting providers or intermediaries for all services associated with an episode of care.

Line 10 – Upside and Downside Risk Sharing

Include: Payments to contracting providers or intermediaries that are subject to shared savings relative to a target with both an up and downside risk component. Arrangements can be comprehensive population, condition specific population, or episode based.

Line 10.1 – Downside Risk Exposure

Include: Include total downside risk that the contracting provider or intermediary could have been exposed to in the prior year. If downside risk is unlimited, cap at the total expected claim cost.

Example A: 85% of premium target with a downside cap at 90%, include 5% of premium.
Example B: 85% of premium target with no downside cap, include 85% of premium.

Line 10.2 – Downside Risk Due / Received

Include: Include total downside risk that the contracting provider or intermediary has paid or would otherwise be required to pay, before considering impacts of deficit forgiveness or contract termination in the prior year.

Example A: 85% of premium target with a downside cap at 90%, actual costs are 92% of premium, include 5% of premium.
Example B: 85% of premium target with no downside cap, actual costs are 92% of premium, include 7% of premium.

Line 10.3 – Actual Recovered Downside Risk

Include: Include total downside risk that the contracting provider or intermediary has paid or would otherwise be required to pay, after considering the impacts of deficit forgiveness or contract termination in the prior year.

Example A: 85% of premium target with a downside cap at 90%, actual costs are 92% of premium, but all deficits are forgiven, include 0% of premium.
Example B: 85% of premium target with no downside cap, actual costs are 92% of premium, only 2% of deficits are collected, include 2% of premium.

ANNUAL STATEMENT BLANK – HEALTH

EXHIBIT 7 – PART 1 – SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payments	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups						
2. Intermediaries						
3. All other providers						
4. Total capitation payments						
Other Payments:						
5. Fee-for-service			XXX	XXX		
6. Contractual fee payments			XXX	XXX		
7. Bonus/withhold arrangements – fee-for-service			XXX	XXX		
8. Bonus/withhold arrangements – contractual fee payments			XXX	XXX		
9. Non-contingent salaries			XXX	XXX		
10. Aggregate cost arrangements			XXX	XXX		
11. All other payments			XXX	XXX		
12. Total other payments			XXX	XXX		
13. Total (Line 4 plus Line 12)		100%	XXX	XXX		

EXHIBIT 7 – PART 1B – SUMMARY OF TRANSACTIONS WITH PROVIDERS DIRECT MEDICAL PAYMENTS TABLE 1

Payment Method	1 Comprehensive (Hospital & Medical) - Individual	2 Comprehensive (Hospital & Medical) - Group	3 Title XVIII - Medicare	4 Title XIX - Medicaid	5 Medicare Supplement	6 Vision Only	7 Dental Only	8 Stand-Alone Medicare Part D Coverage	9 Other Health
Capitation Payments:									
1. Medical groups									
2. Intermediaries									
3. All other providers									
4. Total capitation payments									
Other Payments:									
5. Fee-for-service									
6. Contractual fee payments									
7. Bonus/withhold arrangements – fee-for-service									
7.1 Bonus payment exposure									
7.2 Bonus payments made									
8. Bonus/withhold arrangements – contractual fee payments									
8.1 Bonus payment exposure									
8.2 Bonus payments made									
9. Bundled payments									
10. Upside and downside risk sharing									
10.1 Downside risk exposure									
10.2 Downside risk due / received									
10.3 Actual recovered downside risk									
11. Non-contingent salaries									
12. Aggregate cost arrangements									
13. All other payments									

14. Total other payments									
15. Total (Line 4 plus Line 14)									

EXHIBIT 7 – PART 1B – SUMMARY OF TRANSACTIONS WITH PROVIDERS CEDED REINSURANCE AMOUNT TABLE 2

Payment Method	1 Comprehensive (Hospital & Medical) - Individual	2 Comprehensive (Hospital & Medical) - Group	3 Title XVIII - Medicare	4 Title XIX - Medicaid	5 Medicare Supplement	6 Vision Only	7 Dental Only	8 Stand-Alone Medicare Part D Coverage	9 Other Health
Capitation Payments:									
1. Medical groups									
2. Intermediaries									
3. All other providers									
4. Total capitation payments									
Other Payments:									
5. Fee-for-service									
6. Contractual fee payments									
7. Bonus/withhold arrangements – fee-for-service									
7.1 Bonus payment exposure									
7.2 Bonus payments made									
8. Bonus/withhold arrangements – contractual fee payments									
8.1 Bonus payment exposure									
8.2 Bonus payments made									
9. Bundled payments									
10. Upside and downside risk sharing									
10.1 Downside risk exposure									
10.2 Downside risk due / received									
10.3 Actual recovered downside risk									
11. Non-contingent salaries									
12. Aggregate cost arrangements									
13. All other payments									
14. Total other payments									
15. Total (Line 4 plus Line 14)									

EXHIBIT 7 – PART 1B – SUMMARY OF TRANSACTIONS WITH PROVIDERS NET MEDICAL EXPENSE PAYMENT TABLE 3

Payment Method	1 Comprehensive (Hospital & Medical) - Individual	2 Comprehensive (Hospital & Medical) - Group	3 Title XVIII - Medicare	4 Title XIX - Medicaid	5 Medicare Supplement	6 Vision Only	7 Dental Only	8 Stand-Alone Medicare Part D Coverage	9 Other Health
Capitation Payments:									
1. Medical groups									
2. Intermediaries									
3. All other providers									
4. Total capitation payments									
Other Payments:									
5. Fee-for-service									
6. Contractual fee payments									
7. Bonus/withhold arrangements – fee-for-service									
7.1 Bonus payment exposure									
7.2 Bonus payments made									
8. Bonus/withhold arrangements – contractual fee payments									
8.1 Bonus payment exposure									

8.2 Bonus payments made										
9. Bundled payments										
10. Upside and downside risk sharing										
10.1 Downside risk exposure										
10.2 Downside risk due / received										
10.3 Actual recovered downside risk										
11. Non-contingent salaries										
12. Aggregate cost arrangements										
13. All other payments										
14. Total other payments										
15. Total (Line 4 plus Line 14)										

EXHIBIT 7 – PART 2 – SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
9999999 Totals			XXX	XXX	XXX