NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 7/18/23

Virtual Meeting

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP
Tuesday, July 25, 2023
3:00 – 4:00 p.m. ET / 2:00 – 3:00 p.m. CT / 1:00 – 2:00 p.m. MT / 12:00 – 1:00 p.m. PT

ROLL CALL

Steve Drutz, Chair	Washington	Tish Becker	Kansas
Matthew Richard, Vice Chair	Texas	Danielle Smith/Debbie Doggett	Missouri
Wanchin Chou	Connecticut	Michael Muldoon	Nebraska
Carolyn Morgan/Kyle Collins	Florida	Tom Dudek	New York
		Diana Sherman	Pennsylvania

NAIC Support Staff: Crystal Brown

AGENDA

1) Consider Adoption of its April 17 and May 17 Minutes—*Steve Drutz (WA)* — Attachment One

2) Consider Adoption of the 2023 Health Risk-Based Capital Newsletter—*Steve Drutz (WA)* — Attachment Two

3) Consider Adoption of the 2022 Health RBC Statistics—*Steve Drutz (WA)* — Attachment Three

4) Consider Exposure of Proposal 2023-11-H (XR014 Fee-For-Service & Other Risk Revenue-Medicare & Medicaid)—*Steve Drutz (WA)* — Attachment Four

5) Receive Comments and Consider Referral of the Health Test Language Proposal to the Blanks (E) Working Group—*Steve Drutz (WA)* — Attachment Five
   - New York Comment Letter—*Amanda Fenwick (NY)* — Attachment Six

6) Receive an Update from the American Academy of Actuaries (Academy)
   - Health Care Receivables—*Kevin Russell (Academy)*
   - H2 Underwriting Review—*Derek Skoog (Academy)* — Attachment Seven

7) Consider Adoption of its Working Agenda—*Steve Drutz (WA)* — Attachment Eight

8) Receive an update on the Excessive Growth Charge Ad Hoc Group—*Steve Drutz (WA)*

9) Discuss Pandemic Risk—*Steve Drutz (WA)*

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

11) Adjournment

Draft: 7/10/23

Health Risk-Based Capital (E) Working Group
Virtual Meeting
April 17, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 17, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair (TX); Wanchin Chou, Qing He, and Sarah Mu (CT); Frances Tay and Benjamin Ben (FL); Tish Becker (KS); Danielle Smith and Debbie Doggett (MO); Lindsay Crawford, Michael Muldoon, and Margaret Garrison (NE); and Tom Dudek (NY).

1. Adopted its Spring National Meeting Minutes

Chou made a motion, seconded by Muldoon, to adopt the Working Group's March 21 minutes (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Two*). The motion passed unanimously.

2. Referred Proposal 2023-01-CA to the Capital Adequacy (E) Task Force for Exposure

Drutz said the intent is to refer proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure, which the Working Group exposed at the Spring National Meeting for 20 days. No comments were received. Drutz said the purpose of the proposal was to clarify the instructions for stop loss business in the health risk-based capital (RBC) formula and align the life and property/casualty (P/C) RBC formulas with these changes. The following minor editorial changes were made to the proposal: 1) the "i.e." references were replaced with "e.g."; 2) the reference to "treaty" in the example provided under the Calendar Year was corrected to "contract"; and 3) the proposal number on the proposal form was corrected.

Hearing no objections, the Working Group agreed to refer proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure.

3. Received an Update from the Academy on the Health Care Receivables Project

Kevin Russell (American Academy of Actuaries—Academy) provided an overview and update to the Working Group on the status of the health care receivable (HCR) factor review project. He provided a brief history, noting that Exhibit 3A was implemented in the Health Annual Statement Blank in 2013, which provides a follow-up study on HCRs, and an analogous exhibit was implemented in the Life, Accident and Health (A&H)/Fraternal Annual Statement Blank in 2021. He said the original RBC factor for all types of HCRs was 0.05. He said in 2016, the Academy recommended a change to the factors based on an analysis of amounts collected against receivables compared to admitted receivable assets. He said there was a separate analysis of drug rebates versus the other five types combined. For drug rebates, the 0.05 factor provides a likelihood of between 90% and 95% that the collected amounts would cover the admitted asset plus the amount added to the H3 credit risk calculation. Russell noted that the second largest category of receivables is claim overpayment receivables, and a separate analysis was considered but rejected in favor of including them with the other four types. The Academy recommended the following current factors: 0.05 for drug rebates and 0.19 for all other HCRs.

Russell noted that HCRs have been changing over the years, and drug rebate receivables continue to be the largest portion and still growing; i.e., 48% in 2014 and 65% in 2021. He said claim overpayment receivables have always been the second largest, but their percentage is shrinking—20% in 2014 to 14% in 2021—and risk-sharing receivables are growing as a percentage—3% in 2014 to 7% in 2021.

Russell said the Academy has looked at the 2018–2021 data provided for the Other HCRs, and less than one-third of the Other HCR (for 2018 through 2021) dollars have any description. He said a good amount have descriptions consistent with expectations, such as government programs (e.g., Medicare, Medicaid, and the Children's Health Insurance Program [CHIP]). However, there is a good amount where the descriptions do not seem to be appropriate for items that become a portion of incurred claims via the Underwriting and Investment (U&I) Exhibit Part 2. Examples are: 1) Reinsurance – Reinsurance receivables are part of the H3 Credit Risk but in a different section than HCRs; reinsurance is separately accounted for on the U&I Exhibit Part 2; 2) Interest – Investment income receivables are part of the H3 Credit Risk but in a different section than HCRs; and 3) Admin Fee – The H4 Business Risk covers administrative expenses. Russell said the Academy is considering making inquiries through the NAIC to better understand why these receivables are being reported as such, and the goal would be to produce recommendations to improve instruction clarity or provide additional guidance.

Russell said the Academy is investigating the following questions: 1) whether performance is better for drug rebates compared to the other five categories of HCRs for the filing companies whose receipts do not cover their accrual; 2) whether company performance has improved over time for the filing companies whose receipts do not cover their accrual (an outlier poor performance year might be excluded from the analysis to produce new recommended factors); 3) whether larger companies perform better than smaller ones for the filing companies whose receipts do not cover their accrual (this could indicate that smaller factors could be appropriate for larger receivable amounts, similar to the treatment of the Experience Fluctuation Risk component of the H2 Underwriting Risk).

David Quinn (Academy) shared a graphical representation of the initial analysis results with the Working Group (Attachment XX). He said the density plots show how well companies collected if they did not collect at least 100%. Taller peaks towards 100% are desirable, while masses above 0% could be poor reporting or failure to collect on the receivable. The left-side charts are by year. The overlapping suggests that reporting is consistent across years. The right-side charts are by company size measured by total HCR dollars. The medium and large tiers are defined by $1 million and $10 million, respectively. Each tier is noticeably different in its distribution and thus may have different H3 risks as a function of size. Quinn said larger HCR companies typically did better than smaller ones, which has given rise to the consideration of using a tiered factor approach.

Muldoon said it is interesting that claims overpayment appears to be a much bigger group getting no collections in the prior year, and it could have been estimated erroneously, or there is a dispute with a company that thinks they have made overpayments, but the provider disagrees. Quinn agreed that this is very plausible, and he said it could be the size, as fewer companies hold this type of receivable, so there is more volatility from a small sample size. Russell said the receivable is set up, but the collection often does not come as a separate payment against the accruals. Rather, it comes as an offset made against future claim payments. This may be difficult for companies to quantify because it looks like an adjustment to a claim. He said a large portion is not reporting any collections against the accruals made, and this may be an inquiry to be made.

Drutz asked if the items identified in the analysis as questionable or incorrect were omitted from the analysis. Russell said they were not omitted, and in many cases, they had recoveries reported. The question was the propriety of the receivable type that they were reported as and if it was truly an HCR or some other type of receivable. Drutz asked if the clarification of the Annual Statement Instructions provided any improvement in the data integrity in the last several years. Russell said the Academy did not see much difference in the data integrity in the last four years.

Robin Marcotte (NAIC) asked if it was not a true reinsurance recoverable but instead perhaps related to Medicare or Medicaid. Russell said that is something that has been considered, and it is not uncommon on the Medicaid side for states to keep out of their managed care capitations; i.e., claims in excess of $500,000 for the plan year.

Russell said the state may ask the health plan to pay the whole claim and then submit a stop loss request back to the state, so the HCR could be mislabeled.

The Working Group agreed that it wants the Academy to continue its work on the HCR factor review and prepare a list of possible inquiries.

4. Received an Update from the Academy on the H2 – Underwriting Risk Review

Derek Skoog (Academy) said the Health Solvency Work Group has been working in several different subgroups to advance the following topics: 1) redesigning the structure of the underwriting risk formula; 2) data analysis; and 3) redesigning the managed care credit. He said the Work Group continues to work towards providing more analyses related to where it is seeing volatility in the performance of various lines of business over time and what that may imply for initial underwriting risk factors and structural changes.

5. Discussed Pandemic Risk

Drutz said the Working Group agreed to begin discussing pandemic risk at the Spring National Meeting, and he asked if state insurance regulators consider it to be a missing risk. Muldoon said he has not seen any definitive studies about the impact on RBC because of the pandemic. He said in 2020, the government stepped in and shut down all elective surgeries, and because health companies did not have to cover them, many had a big underwriting gain; however, many companies experienced an increase in telehealth and mental health services, as well as the COVID-19 vaccine. He asked if the assumption is that there would be the same type of government action to step in when the next pandemic hits, and if so, the risk of many health companies becoming insolvent could be minimized. He said he was not clear on what could be changed in the RBC at this time. Drutz noted the limited hospital space during the pandemic, and he asked how the limited space could affect the risk. He also noted the pent-up demand for medical care following the worst of the pandemic, and he asked if this demand could have a bigger effect than the pandemic. He said there appeared to be more volatility for some carriers in 2021 and 2022 because of this pent-up demand.

Drutz asked if anyone has any knowledge or information on modeling pandemic risk and if any industry participants model for pandemic risk. Muldoon said Nebraska has not seen much on modeling pandemic risk in its reviews of companies. Drutz asked if anyone has any information related to the Solvency II requirements for modeling pandemic risk. Richard said he has seen some requirements for Solvency II for the United Kingdom (UK). He said the approach was as follows: if the number of policyholders is X, assume X percent will have an office visit, X will have a more severe case, and X will have a higher severity case. Then, there is an assumed frequency for each of the three levels of severity multiplied by the corresponding costs. Richard said the templates for the calculation are all public through the European Insurance and Occupational Pensions Authority (EIOPA).

Drutz asked if the Working Group feels it should dive deeper into pandemic risk, and if so, if there are any thoughts on how to begin this work or questions to consider. Muldoon suggested looking at what work the Society of Actuaries (SOA) is still doing with its monitoring spreadsheets. He also suggested looking at the RBC filings from 2020–2022 to see if any discernable differences were noted. Drutz suggested looking to see if there was a general decline in RBC results. Muldoon also suggested segregating the companies into groups, such as major medical.

The Working Group agreed to begin looking at pandemic risk.

6. Discussed Other Matters

Drutz said the Health Test Ad Hoc Group met April 12, and a question was raised on the proposal's effective date and when a company would move if they passed the health test based on the language currently included in it. The Ad Hoc Group determined that that language was not overly clear, and it would be beneficial to look at it further. As a result, the Ad Hoc Group will meet again April 26 to look at clarifications for the language on "Passing the Test" and "Failing the Test."

Drutz said the Capital Adequacy (E) Task Force established an ad hoc group at the Spring National Meeting to review or analyze current non-investment charges, missing risks, and modernizing asset concentration instructions. He said if anyone has any thoughts on non-investment charges or missing risks in the health RBC formula, they should reach out to him or Crystal Brown (NAIC).

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

SharePoint/NAIC Support Staff Hub/Member Meetings/

Attachment Two
Capital Adequacy (E) Task Force
8/14/23

Draft: 7/10/23

Health Risk-Based Capital (E) Working Group
Virtual Meeting
May 17, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met May 17, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, and Aaron Hodges (TX); Wanchin Chou and Sarah Mu (CT); Benjamin Ben (FL); Danielle Smith and Debbie Doggett (MO); and Tom Dudek (NY).

1. Exposed the Health Test Proposal

Drutz said the Working Group established the Health Test Ad Hoc Group in 2018 to review the existing health test language in the Annual Statement Instructions for all lines of business. He said the Working Group initially identified the concern when pulling the data for the Health Care Receivables (HCR) factor review. In 2016, approximately 28% of the overall health premiums were reported on the life blank, and 72% reported on the health blank, with less than 1% reported in the property/casualty (P/C) blank.

Drutz said in 2016, the life blank did not provide the same level of detail on health business and risks as the health blank. He said the following concerns were identified from a risk-based capital (RBC) perspective: 1) factor development; and 2) differences between the formulas. From a factor development perspective, only the data contained within the health blank could be used due to inconsistencies between the blanks. An example is HCRs, for which the factors are developed from data in Exhibit 3, Exhibit 3a, and Underwriting and Investment (U&I) Part 2B of the annual statement. These schedules were previously only available in the Health Annual Statement Blank. Drutz noted that there are also formula differences to consider; i.e., the health formula is driven primarily by the Underwriting Risk component, which in 2018 made up approximately 60–70% of the overall risk within the formula, while the life formula was driven more by asset risk. He also noted that the risk components are not accounted for identically between the health and life formulas. An example is that the health formula includes an excessive growth and HCR charge not included in the life RBC formula.

Drutz said prior to the establishment of the Ad Hoc Group, the Working Group reached out to other NAIC groups, such as the Financial Analysis (E) Working Group, the Financial Stability (E) Task Force, and the Blanks (E) Working Group to garner their feedback. From a financial analysis perspective, issues identified as concerns were group analysis and health insurance industry research and reporting. The Working Group established the Ad Hoc Group to consider the health test language, as it was included in the Annual Statement Instructions in 2018. The Ad Hoc Group was made up of state insurance regulators, industry, and NAIC staff. The health test language at the time the Ad Hoc Group was developed was as follows:

An entity is deemed to have passed the current test if:

> The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year AND The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less AND At least seventy-five percent (75%) of the entity's current year premiums are written in its domiciliary state OR The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

Drutz said the Ad Hoc Group considered two approaches: 1) a bright line test, which was rules-based and maintained the current "test" concept. That is, if the test is passed, the presumption is that the insurer would switch to the health blank unless the state insurance regulator vetoed that move. Additional tests and considerations would be outlined to determine if special consideration should be given to the reporting entity moving to the health blank (e.g., separate accounts, large book of long-term care (LTC) business, etc.); or 2) an analysis/risk-based approach that would change the "test" concept to become an "analysis" process. The "test" would instead provide metrics to the state insurance regulator. When a metric exceeds the guideline, the state insurance regulator should consider whether the insurer should be reporting on the health blank. Drutz said the Ad Hoc Group always maintained that with either approach, the full authority and discretion in determining the blank to be filed by the reporting entity would remain with the domiciliary state. He said the Ad Hoc Group ultimately agreed to move forward and maintain a bright line test approach.

Drutz said the Phase 1 proposal was developed and exposed by the Working Group in December 2021. The primary components of this proposal included the following revisions: 1) removal of the requirements for licensed and actively writing in five states or less; 75% of current premiums are written in the domiciliary state; and the "or" statement for the premium and reserve ratio equal to 100%; 2) added a clarifying sentence to the Life and P/C portion of the Health Test language instructions that companies that report separate accounts or protected cells are not subject to the results of the health test but should continue to report on the existing blank; and 3) the General Interrogatory references for Life were updated to pull from the current Analysis of Operations by Line of Business—Accident and Health instead of the Life RBC.

Drutz said the Ad Hoc Group also discussed the premium and reserve ratios during the Phase 1 work. At one point, consideration was given to removing the reserve ratio as a requirement. Drutz said the Ad Hoc Group determined to maintain the existing 95% premium and reserve ratios for the time being and evaluate any changes to this requirement as part of Phase 2. The Working Group referred the Phase 1 proposal to the Blanks (E) Working Group in February 2022, and it was adopted for year-end 2022 reporting by the Blanks (E) Working Group.

Drutz said the Ad Hoc Group began its review of the premium and reserve ratios after the referral of the Phase 1 proposal. The primary discussion revolved around the reserve ratio. The focus of consideration and discussion by the Ad Hoc Group was on asset valuation reserve (AVR)/interest maintenance reserve (IMR), the actuarial opinion and asset adequacy testing (AAT), and the reserve ratio calculation itself. He said a question was raised on AAT when a reporting entity transitions from the life blank to the health blank and if the entity must continue to submit a Statement of Actuarial Opinion (SAO) based on asset adequacy analysis. The Ad Hoc Group worked closely with the Health Actuarial (B) Task Force and identified that there was not a general requirement that would require a health insurer to perform AAT, but there were other requirements that could compel such an analysis. The Ad Hoc Group also worked with the Working Group to draft a referral letter to ask the Health Actuarial (B) Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that says AAT must be completed regardless of statement type if such requirements are met.

Drutz said the discussion around calculating the life reserve ratio was multi-faceted. He said the initial concern identified in the existing calculation was that the numerator pulled from Exhibits 5, 6, and 8, while the denominator pulled from the Liabilities page. The Ad Hoc Group noted that using the varying schedules between the numerator and denominator was a less straightforward approach to the calculation. Drutz said the Ad Hoc Group started its initial review by identifying equivalent lines in Exhibits 5, 6, or 8 to the Liabilities reference in the denominator. After identifying these, the Ad Hoc Group recalculated the results to ensure consistency. However, as the Ad Hoc Group worked through this exercise, it identified an inconsistency in the lines used in the calculation. Some were reported on a net basis, while others were reported on a gross basis. As a result, the Ad Hoc Group identified and analyzed the results of the reserve ratio to be calculated on an all-net or all-gross basis. It

determined that there was no material effect to one over the other, and it moved forward with a net basis approach, which will keep the premium and reserve ratio on a net basis.

Drutz said based on the analysis of the Ad Hoc Group, a Phase 2 proposal was drafted (Attachment XX). This proposal includes revisions to the General Interrogatories, Part 2, Health Test Premium and Reserve Ratio calculations for life, property, and health. The changes reflected in this proposal were to clarify and create greater transparency in the calculation of both the numerator and the denominator in both the premium and reserve calculation. In both the premium and reserve ratios, the numerator and the denominator were calculated using separate schedules. Drutz said the changes align the denominator to pull from the same schedules as the numerator where possible. For example, the denominator in the calculation of the reserve ratio in the life general interrogatories was calculated using the Liabilities page, but the numerator utilized Exhibits 6 and 8. For greater transparency, the Ad Hoc Group then utilized those same schedules to now calculate the denominator. He said the current calculation of the reserve ratio utilizes both gross and net amounts, creating inconsistencies in the calculation. It was concluded that the net basis was the best way to move forward. This allowed for both the premium and reserve ratio to be calculated on a net basis. Drutz said additional clarifying instructions were also incorporated into the health test language on the timing of when a company would move if it has passed the test.

Drutz said the Ad Hoc Group also discussed whether the 95% ratio should be lowered, but it determined that no changes should be made at this time due to the extensive changes in the life and property annual statement filings for capturing health data. He said the Ad Hoc Group felt that all health data changes should be implemented, as well as the proposed health test changes, and then re-evaluated in a few years.

Hearing no objections, the Working Group exposed the proposal to the Health Risk-Based Capital (E) Working Group, the Property and Casualty Risk-Based Capital (E) Working Group, and the Life Risk Based-Capital (E) Working Group for a 45-day public comment period ending June 30.

2. Discussed Other Matters

Drutz said proposal 2022-09-CA was adopted for year-end 2023 reporting, and it revises the affiliated investment portion of the health RBC formula. He said as NAIC staff worked through the implementation of the changes, it was found that some clarifications were needed in the form of editorial changes, specifically for indirectly owned alien insurance subsidiaries and affiliates. He said the Working Group will work with the Capital Adequacy (E) Task Force on these editorial changes.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Newsletter Items for Adoption for 2023 for Health RBC:

Date: July 2023
Volume: 25.1

Page 1: Intro Section:

What Risk-Based Capital Pages Should Be Submitted?

For the year-end 2023 health risk-based capital (RBC) filing, submit hard copies of pages **XR001 through XR027** to any state that requests a hard copy in addition to the electronic filing. Beginning with year-end 2007, a hard copy of the RBC filings was not required to be submitted to the NAIC. Other pages, outside of pages XR001 through XR027, do not need to be submitted. Those pages would need to be retained by the company as documentation.

Page 1+: Items Adopted for 2023:

Modification to the Affiliated Investment Structure and Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA during its March 23 meeting to revise the instructions and structure of the Affiliated Investment pages (pages XR002–XR004) to provide consistent treatment of affiliated investments between the Health, Life, and Property/Casualty (P/C) RBC formulas. The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA (MOD) during its June 30 call. The modified proposal clarified the examples provided for the Indirectly Owned Alien Insurance Affiliates/Subsidiaries section within the instructions and added a footnote for the "% Owned" column within the blank.

Preferred Stock Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-10-H during its Dec. 14, 2022, meeting to delete the reference to bond factors and revise for consistency with the P/C RBC preferred stock instructions.

Underwriting Risk – Annual Statement – Analysis of Operations References

The Capital Adequacy (E) Task Force adopted proposal 2022-11-H during its Dec. 14, 2022,

meeting. The purpose of this proposal was to update the annual statement source descriptions and align the lines of business on pages XR013 and XR014 with the changes in the Annual Statement Analysis of Operations based on Blanks proposal 2021-17BWGMOD.

Trend Test Instructions
The Capital Adequacy (E) Task Force adopted proposal 2022-14-H during its March 23 meeting to remove the informational-only trend test instructions.

Renumbering of Page XR008
The Capital Adequacy (E) Task Force adopted proposal 2022-15-H during its March 23 meeting to renumber the lines on page XR008 so it starts with line number 1.

Underwriting Risk Factors – Investment Income Adjustment
The Capital Adequacy (E) Task Force adopted proposal 2022-16-CA during its June 30 meeting. This proposal updated the comprehensive medical, Medicare supplement, and dental and vision factors to include a 5% investment yield adjustment. The revised factors are:

	Comprehensive Medical	Medicare Supplement	Dental & Vision
$0–$3 Million	0.1434	0.0980	0.1148
$3–$25 Million	0.1434	0.0603	0.0711
Over $25 Million	0.0838	0.0603	0.0711

Stop Loss Premiums
The Capital Adequacy (E) Task Force adopted proposal 2023-01-CA during its June 30 meeting. This proposal clarifies the instructions for stop loss premiums in the Underwriting Risk – Experience Fluctuation Risk, Other Underwriting Risk, and Stop Loss Interrogatories.

Page 2+: Editorial Changes:

1. An editorial change was made to the Annual Statement Source column on page XR014 for the following:
    a. Column (1), Line (7) was updated to reference "Pg. 7, Col. 2+3+8+9, Line 17."
    b. Column (7), Line (2) was updated to reference "Pg. 7, Col. 8, Lines 1+2."
    c. Column (7), Line (3) was updated to reference "Pg. 7, Col. 9, Lines 1+2."
2. An editorial change was made to the instructions for Affiliated Investments to remove the reference "and Line 93999999" from the end of the following sentence: "The total of all reported affiliate/subsidiary stock should equal the amounts reported on Schedule D, Part 2, Section 1, Line 4409999999 plus Schedule D, Part 2, Section 2, Line 5979999999 and should also equal Schedule D, Part 6, Section 1, Line 0999999 plus Line 1899999."
3. An editorial change was made to the Annual Statement Source on page XR023, Lines (5) and (13), to update the line reference to Line 7.
4. An editorial change was made to remove the page number reference from the electronic-only stop loss tables on page XR015 of the forecasting file.

Last Page: RBC Forecasting & Warning:

Risk-Based Capital Forecasting and Instructions

The Health RBC forecasting spreadsheet calculates RBC using the same formula presented in the *2023 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies*, and it can be downloaded from the NAIC Account Manager. The *2023 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies* publication is available for purchase in an electronic format through the NAIC Publications Department. This publication is available for purchase on or about Nov. 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

WARNING: The RBC forecasting spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.

Last Page: 2023 National Association of Insurance Commissioners:

2023 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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Aggregated Health Risk-Based Capital Data
2022 Data as of 7/5/2023

Attachment Three

	2022	2021	2020	2020	2019	2019	2018	2018	2017	2017
	Health RBC	Health RBC	Health RBC Excluding ACA Fees	Health RBC	Health RBC Excluding ACA Fees	Health RBC	Health RBC Excluding ACA Fees	Health RBC	Health RBC Excluding ACA Fees	Health RBC
Companies that have an RBC loaded on the database	1143	1095	1067	1067	1,012	1,012	965	965	937	937
Companies with action levels:	28	12	15	15	31	15	18	18	42	21
Percentage of total RBC's loaded	2.45%	1.10%	1.41%	1.41%	3.06%	1.48%	1.87%	1.87%	4.48%	2.24%
Company Action Level - Trend Test	13	15	12	12	27	14	13	13	23	12
Company Action Level	6	5	4	4	14	3	4	4	24	10
Regulatory Action Level	10	2	3	3	5	3	5	5	10	5
Authorized Control Level	0	2	2	2	3	2	2	2	0	0
Mandatory Control Level	12	3	6	6	9	7	7	7	8	6
Total H0 (H0 - Asset Risk - Affiliates w/RBC)	6,291,267,994	6,077,847,595	5,192,392,682	5,192,392,682	4,782,424,393	4,782,424,393	4,487,634,571	4,487,634,571	4,332,880,131	4,332,880,131
Total H1 (H1 - Asset Risk - Other)	14,838,262,774	15,015,094,709	11,292,103,225	11,292,103,225	9,743,938,557	9,743,938,557	8,589,245,210	8,589,245,210	8,315,790,867	8,315,790,867
Total H2 (H2 - Underwriting Risk)	58,513,470,158	52,350,782,384	45,819,164,666	45,819,164,666	44,037,638,071	44,037,638,071	40,572,604,055	40,572,604,055	38,787,031,590	38,787,031,590
Total H3 (H3 - Credit Risk)	5,526,140,601	4,762,549,718	4,199,732,859	4,199,732,859	3,626,933,231	3,626,933,231	3,408,034,022	3,408,034,022	3,143,155,975	3,143,155,975
Total H4 (H4 - Business Risk)	8,609,609,597	7,882,405,838	7,481,764,896	7,481,764,896	6,571,143,274	6,571,143,274	6,468,297,728	6,468,297,728	5,739,438,653	5,739,438,653
Total RBC Before Covariance	93,778,751,124	86,088,680,244	73,985,158,328	73,985,158,328	68,762,077,526	68,762,077,526	63,525,815,586	63,525,815,586	60,318,297,216	60,318,297,216
Total Adjusted Capital	220,326,411,094	211,045,740,619	193,852,790,008	193,859,548,232	160,266,143,771	171,305,834,767	156,735,204,883	156,738,377,038	132,169,821,412	142,062,265,048
ACA Fees			6,758,224		11,039,690,995		3,172,155		9,892,443,636	
Authorized Control Level RBC *	36,522,419,595	33,256,637,840	28,853,148,695	28,853,148,695	27,216,649,996	27,216,654,287	25,020,328,688	25,020,329,600	23,228,424,178	23,228,428,544
Aggregate RBC %	603%	635%	672%	672%	548%	629%	626%	626%	526%	612%
Median RBC %	628%	633%	706%	707%	640%	672%	668%	668%	609%	640%
# of Companies with an RBC Ratio of > 10,000%	148	121	143	143	156	156	134	134	112	112
# of Companies with an RBC Ratio of < 10,000% & > 1,000%	232	243	259	259	202	215	223	224	201	213
# of Companies with an RBC Ratio of < 1,000% & > 500%	333	356	320	320	257	282	267	267	237	251
# of Companies with an RBC Ratio of < 500% & > 300%	341	301	278	278	267	285	256	255	247	268
# of Companies with an RBC Ratio of < 300% & > 250%	**35**	**32**								
# of Companies with an RBC Ratio of < 250% & > 200%	**25**	**28**								
# of Companies with an RBC Ratio of < 300% & > 200%			52	52	99	59	67	67	97	71
# of Companies with an RBC Ratio of < 200% **& <> 0%**	28	12	14	14	31	15	18	18	42	21
# of Companies with an RBC Ratio of Zero	1	2	1	1	0	0	0	0	1	1
Total Companies with RBC	1,143	1,095	1,067	1,067	1,012	1,012	965	965	937	937
Total Revenue	998,270,459,614	888,638,436,244	806,712,759,846	806,712,759,846	731,800,228,651	731,800,228,651	689,327,716,795	689,327,716,795	643,856,047,265	643,856,047,265
Underwriting Deductions	973,220,456,829	873,483,482,222	774,563,533,665	774,563,533,665	715,077,656,883	715,077,656,883	668,918,380,940	668,918,380,940	625,985,270,784	625,985,270,784
Aggregate Premium	285,669,735,439	278,391,052,611	277,819,028,596	277,819,028,596	268,818,431,635	268,818,431,635	271,400,290,484	271,400,290,484	262,662,393,744	262,662,393,744
Aggregate Net Incurred Claims	806,428,955,513	721,841,094,774	622,491,724,778	622,491,724,778	585,439,850,066	585,439,850,066	541,009,426,163	541,009,426,163	511,376,831,853	511,376,831,853

* Authorized Control Level RBC amount reported in the Health RBC Excluding ACA Fees column is pulled from Line (18), page XR026, and the Authorized Control Level RBC amount reported in the Health RBC column is pulled from Line (4), page XR027.

Source: NAIC Financial Data Repository

Attachment Four

Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE: 7-12-23

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

FOR NAIC USE ONLY

Agenda Item # 2023-11-H
Year 2024

DISPOSITION

ADOPTED:
☐ TASK FORCE (TF) _____
☐ WORKING GROUP (WG) _____
☐ SUBGROUP (SG) _____

EXPOSED:
☐ TASK FORCE (TF) _____
☐ WORKING GROUP (WG) _____
☐ SUBGROUP (SG) _____

REJECTED:
☐ TF ☐ WG ☐ SG _____

OTHER:
☐ DEFERRED TO _____
☐ REFERRED TO OTHER NAIC GROUP
☐ (SPECIFY) _____

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

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

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The purpose of this proposal is to include Medicare and Medicaid amounts in Column (1), Line (4) – Other Health Risk Revenue and Line (10) – Fee For Service Offset of page XR013. Column (1), Lines (4) and (10) on page XR014 will be updated to reflect the Columns 8 & 9 in the annual statement reference.

Additional Staff Comments:

The proposed change will create consistent treatment of Medicare and Medicaid amounts throughout Column (1) of page XR013.

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

† Annual Statement Source

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual & Group	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1)	Premium	Page 7, Columns 2 & 3, Lines 1 + 2	Page 7, Column 4, Line 1 + 2	Page 7, Columns 6 & 5, Line 1 + 2			Page 7, Column 14, Lines 1 + 2	
(2)	Title XVIII-Medicare	Page 7, Column 8, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 8, Lines 1 + 2
(3)	Title XIX-Medicaid	Page 7, Column 9, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 9, Lines 1 + 2
(4)	Other Health Risk Revenue	Page 7, Columns 2 + 3 + **8** + **9**, Line 4	XXX	Page 7, Columns 6 & 5, Line 4			XXX	
(7)	Net Incurred Claims	Page 7, Columns 2 + 3 + 8 + 9, Line 17	Page 7, Column 4, Line 17	Page 7, Columns 6 & 5, Line 17			XXX	
(10)	Fee-For-Service Offset	Page 7, Columns 2 + 3 + **8** + **9**, Line 3	XXX	Page 7, Columns 6 & 5 , Line 3			XXX	
(17)	Maximum Per-Individual Risk After Reinsurance	Gen Int Part 2, Lines 5.31 + 5.32	Gen Int Part 2 Line 5.33	Gen Int Part 2 Line 5.34			XXX	XXX

Denotes items that must be manually entered on filing software.

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

		FOR NAIC USE ONLY
	DATE: 5-17-23	Agenda Item #
CONTACT PERSON:	Crystal Brown	Year 2024
TELEPHONE:	816-783-8146	Changes to Existing Reporting [ ]
EMAIL ADDRESS:	cbrown@naic.org	New Reporting Requirement [ ]
ON BEHALF OF:	Health Risk-Based Capital (E) Working Group	**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**
NAME:	Steve Drutz	No Impact [ ] Modifies Required Disclosure [ ]
TITLE:	Chair	**DISPOSITION**
AFFILIATION:	WA Office of Insurance Commissioner	[ ] Rejected For Public Comment [ ] Referred To Another NAIC Group [ ] Received For Public Comment [ ] Adopted Date [ ] Rejected Date [ ] Deferred Date [ ] Other (Specify)
ADDRESS:		

BLANK(S) TO WHICH PROPOSAL APPLIES

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

Anticipated Effective Date:

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Test Language and General Interrogatories.

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

The purpose of this change is to clarify and create better transparency in the calculation of the premium and reserve ratios in the health test.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** **This section must be completed on all forms.** **Revised 7/18/202**

INSTRUCTIONS

GENERAL

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

1. **Health Statement Test:**

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

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

Passing the Test:

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

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

If a reporting entity is a) licensed as a life and health insurer; b) completes the Life, Accident and Health annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end. For example, if the reporting entity reports premium and reserve ratios of 95% or greater in 20X1 and again reports premium and reserve ratios of 95% or greater in 20X2, the reporting entity is deemed to have passed the Health Statement Test as of 20X2. Therefore, the reporting entity would begin completing the health statement in the first quarter of 20X4. ~~(As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.)~~

	20X1	20X2	20X3	20X4
Premium Ratio	95% or greater	95% or greater	Work with domestic regulators to move effective Quarter 1 20X4	Move to Orange Blank Quarter 1
Reserve Ratio	95% or greater	95% or greater		

As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.

Variances from following these instructions:

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

PART 2 – LIFE ACCIDENT HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

Life and Accident Health Companies/Fraternal Benefit Societies:

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

   All reporting entities should file the test; however, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

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

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health: The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus Line 1, Column 13 in part (~~include only Medicare Part D and Stop Loss and Minimum Premium~~exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies) of the reporting year's annual statement.	Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health: The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus Line 1, Column 13 in part (exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies) of the prior year's annual statement. ~~**Health Premium** values listed in the statement value column (Column 1) of the reporting year's Life RBC report:~~ ~~Individual Lines:~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ ~~Dental and Vision~~ ~~Group Lines:~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ ~~Stop Loss and Minimum Premium~~ ~~Dental and Vision~~ ~~Federal Employee Health and Benefit Plan~~
2.2	Premium Denominator	~~Premium and Annuity Considerations (Page 4, Line 1) of the reporting year's annual statement~~Analysis of Operations by Lines of Business – Summary, Column 1, Line 1 of the reporting year's annual statement.	Analysis of Operations by Lines of Business – Summary, Column 1, Line 1~~Premium and Annuity Considerations (Page 4, Line 1)~~ of the prior year's annual statement
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4(a)	Reserve Numerator	Net A&H Policy and Contract Claims	Net A&H Policy and Contract Claims

		without Credit Health (Exhibit 8, Part 1, Line 4.4, Column 9 and Column 11 (excluding Dread Disease, Disability Income and Long-Term Care)) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns 10, 11, 12 and Dread Disease included in Column 13) for Total (Net) ~~Unearned Premiums~~ (Line 17) or the reporting year's annual statement. ~~and Future Contingent Benefits (Line 4)~~	without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11 (excluding Dread Disease, Disability Income and Long-Term Care)) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns 10, 11, 12 and Dread Disease included in Column 13) for ~~Unearned Premiums~~ Total (Net) (Line 17) of the prior year's annual statement. ~~and Future Contingent Benefits (Line 4)~~
2.5	Reserve Denominator	Aggregate Reserve (~~Page 3, Column 1, Lines 1+2+4.1+4.2~~Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4) of the reporting year's annual statement. ~~minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)~~	Aggregate Reserve (Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4 of the prior year's annual statement. ~~Page 3, Column 1, Lines 1+2+4.1+4.2~~) ~~minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)~~
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

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

INSTRUCTIONS

For Completing Health Annual Statement Blank

GENERAL

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

1. **Health Statement Test:**

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

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

Passing the Test:

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

Failing the Test:

If a reporting entity, licensed as a life, accident and health or property and casualty insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it will revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of the second year following the reporting year. For example, if the reporting entity reports a premium or reserve ratio below 95% in 20X1, the reporting entity is deemed to have not passed the Health Statement Test. Therefore, the reporting entity would revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of 20X3. However, if the reporting entity reports premium and reserve ratios of 95% or greater in 20X2, it should work with its domiciliary regulator to determine the appropriate blank to file on to avoid movement back and forth between blanks. (As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.)

If a reporting entity, licensed as a health insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it should continue to file the health annual statement.

Variances from following these instructions:

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

PART 2 – HEALTH INTERROGATORIES

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

   All reporting entities should file the test.

   Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	Health Premium values listed in the Analysis of Operations by Lines of Business, Line 1 plus Line 2, Column 2 through Column ~~8~~9 plus Line 1 plus Line 2, Column ~~9~~13 in part (excluding credit A&H and dread disease coverage, LTC, Disability Income) of the reporting year's annual statement.	Health Premium values listed in the Analysis of Operations by Line of Business, Line 1 plus Line 2, Column ~~1~~ 2 through Column 9 plus Line 1 plus Line 2, Column 13~~9~~ ~~(~~in part (excluding ~~for~~ credit A&H and dread disease coverage, LTC, Disability Income) ~~Column 10~~ of the ~~reporting~~ prior year's annual statement.
2.2	Premium Denominator	Analysis of Operations by Lines of Business~~Net Premium Income (Page 4, Line 2, Column 2)~~ Column 1, Line 1 plus Line 2 of the reporting year's annual statement.	~~Net Premium Income (Page 4, Line 2, Column 2)~~Analysis of Operations by Lines of Business, Column 1, Line 1 plus Line 2 of the prior year's annual statement.
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4 (a)	Reserve Numerator	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus (Lines 9, 10, 11 and any dread disease coverage reported in Line 12) plus Line 16)~~13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H)~~ + Part 2D (Line 8+14, Column 1 minus ~~(~~Columns ~~9~~10, 11, 12 and any dread disease coverage reported in Column 13) ~~) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc.~~ of the reporting year's annual statement.	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus (Lines 9, 10, 11 and any dread disease coverage reported in Line 12) plus Line 16) ~~13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H~~ + Part 2D (Line 8+14, Column 1 minus Columns 10, 11, 12 and any dread disease coverage reported in Column 13~~9~~) ~~include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc.~~ of the ~~reporting~~prior year's annual statement.
2.5	Reserve Denominator	Underwriting and Investment Exhibit, Part 2A, Col. 1, Line 4.4 plus Underwriting and Investment Exhibit, Part 2, Column 1, Line 5 plus Underwriting and Investment Exhibit, Part 2D, Col. 1, Lines 8+14 plus Page 3, Column 3, Lines 5 + 6 ~~Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7)~~ of the reporting year's annual statement.	Underwriting and Investment Exhibit, Part 2A, Col. 1, Line 4.4 plus Underwriting and Investment Exhibit, Part 2, Column 1, Line 5 plus Underwriting and Investment Exhibit, Part 2D, Col. 1, Lines 8+14 plus Page 3, Column 3, Lines 5 + 6~~Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7)~~ of the prior year's annual statement.
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

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

INSTRUCTIONS

For Completing Property and Casualty Annual Statement Blank

GENERAL

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

1. **Health Statement Test:**

If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Protected Cell Statement is not subject to the results of the Health Statement Test and should continue to complete the property blank.

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

Passing the Test:

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

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

If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end. For example, if the reporting entity reports premium and reserve ratios of 95% or greater in 20X1 and again reports premium and reserve ratios of 95% or greater in 20X2, the reporting entity is deemed to have passed the Health Statement Test as of 20X2. Therefore, the reporting entity would begin completing the health statement in the first quarter of 20X4. ~~(As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.)~~

	20X1	20X2	20X3	20X4
Premium Ratio	95% or greater	95% or greater	Work with domestic regulator to move effective Quarter 1 20X4	Move to Orange Blank Quarter 1
Reserve Ratio	95% or greater	95% or greater		

As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.

Variances from following these instructions:

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

PART 2 – PROPERTY AND CASUALTY INTERROGATORIES

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

   All reporting entities should file the test; however, a reporting entity that is required to also file the Protected Cell Statement is not subject to the results of the Health Statement Test and should continue to complete the property blank.

   Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	**Health Premium** values listed in the ~~Net~~ Premiums ~~Written~~Earned During Year column (Column ~~4~~6) of the reporting year's U&I Part 1~~B~~: Lines 13.1 and 13.2 Lines 15.1, 15.2, 15.4, 15.6, and 15.8 Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium) Line 15.9 in part (exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies~~include only Medicare Part D and Stop Loss and Minimum Premium~~)	**Health Premium** values listed in the Premiums Earned During Year column (Column 4) of the reporting year's U&I Part 1: Lines 13.1 and 13.2 Lines 15.1, 15.2, 15.4, 15.6, and 15.8 Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium) Line 15.9 in part (exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies) ~~**Health Premium** values as listed in the statement value column (Column 1) of the prior year's P&C RBC report:~~ ~~Individual Lines~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ ~~Dental and Vision~~ ~~Group Lines~~ ~~Usual and Customary Major Medical and Hospital~~ ~~Medicare Supplement~~ ~~Medicare Part D~~ ~~Stop Loss and Minimum Premium~~ ~~Dental and Vision~~ ~~Federal Employee Health and Benefit Plan~~
2.2	Premium Denominator	~~Premiums Earned (Page 4, Line 1) of the reporting year's annual statement~~Underwriting and Investment Exhibit, Part 1, Column 4, Line 35	Underwriting and Investment Exhibit, Part 1, Column 4, Line 35~~Premium Earned (Page 4, Line 1) of the prior year's annual statement~~
2.3	Premium Ratio	**2.1/2.2**	**2.1/2.2**
2.4(a)	Reserve Numerator	Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) of the reporting	Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15) (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and

		year's annual statement.	Minimum Premium)) of the prior year's annual statement.
2.5	Reserve Denominator	~~Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3)~~ Part 2A, Unpaid Losses and Loss Adjustment Expenses, (Line 35, Columns 8+9) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the reporting year's annual statement.	Part 2A, Unpaid Losses and Loss Adjustment Expenses, (Line 35, Columns 8+9)~~Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3)~~ plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year's annual statement.
2.6	Reserve Ratio	**2.4/2.5**	**2.4/2.5**

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

From: Ryan, Matthew G (DFS)
To: Brown, Crystal
Cc: Lopez, Amy; Carmello, Bill; Cebula, Michael; Fenwick, Amanda; Hazzard, Dwight J (DFS)
Subject: RE: Exposure Draft Notice: Health Risk-Based Capital (E) Working Group ending 6/30/23
Date: Monday, June 26, 2023 2:59:39 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png

Crystal Brown,

The New York State Department of Financial Services ("NYDFS") appreciates the opportunity to provide comments on the Health Test Proposal exposed by the Health Risk-Based Capital (E) Working Group on May 17, 2023.

The NYDFS objects to the proposal as it relates to licensed life, accident and health insurers and fraternal benefit societies. The NYDFS believes that a reporting entity should only be deemed to have passed the Health Statement Test if it has both a premium ratio and reserve ratio equal to 100% on a gross of reinsurance basis; i.e., an insurer with any life or annuity business should file a Life, Accident and Health annual statement.

A Health annual statement blank may not be suitable for an insurer with life and annuity business as such business will not be presented in a clear and comprehensible manner to regulators as it otherwise would be under a Life, Accident and Health annual statement blank. The exhibits of the Life, Accident and Health annual statement blank are tailored for the distinct types of life and annuity business; this information is not required under the Health annual statement. Furthermore, considering premium and reserve ratios on a net basis could result in an insurer filing a Health annual statement despite having a substantial block of reinsured life and/or annuity business for which the direct liability is their ultimate responsibility. It is preferable to have such information presented in the Life, Accident and Health annual statement blank and to have the reporting entity regulated as a life and accident and health insurer.

If revising the premium and reserve ratio requirements to 100% is not acceptable, then the NYDFS believes that in any case, such ratios should be calculated on a gross of reinsurance basis.

Please feel free to reach out if you have any questions.

Thank you,

Matthew G. Ryan, FSA, CERA, MAAA
Supervising Actuary - Life

New York State Department of Financial Services
One Commerce Plaza, Albany, NY 12257

Phone: (518) 474-7929 | matthew.ryan@dfs.ny.gov

www.dfs.ny.gov

From: Lopez, Amy <alopez@naic.org>
Sent: Thursday, May 18, 2023 4:14 PM
To: Brown, Crystal <CBrown@naic.org>
Subject: Exposure Draft Notice: Health Risk-Based Capital (E) Working Group ending 6/30/23

Distributed to the Health Risk-Based Capital (E) Working Group, Lie Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group Members, Interested Regulators, and Interested Parties

The Health Test Proposal is being exposed for a 45-day comment period. Please submit comments to Crystal Brown by COB June 30, 2023.

NAIC Staff Contact:
Crystal Brown
cbrown@naic.org
816.783.8146

Amy Lopez
Sr. Administrative Assistant – FRS

O: 816-783-8423
W: www.naic.org

Follow the NAIC on

July 13, 2023

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

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

Dear Chair Drutz:

On behalf of the Health Underwriting Risk Factors Analysis Work Group of the Health Solvency Subcommittee of the American Academy of Actuaries (Work Group),[1] I appreciate the opportunity to provide these updates to the National Association of Insurance Commissioners (NAIC) Health Risk-Based Capital (E) Working Group in response to the request to comprehensively review the H2—Underwriting Risk Component and the Managed Care Credit Calculation in the Health Risk-Based Capital (HRBC) formula.

As part of the work group's review of the H2—Underwriting Risk Component, we identified several components of the current formula that merit discussion within the NAIC HRBC Working Group. We have described the issues below and would appreciate the opportunity to discuss them with the Working Group at the July 25, 2023, NAIC HRBC Working Group meeting.

For background, the critical source of the Experience Fluctuation Risk (EFR) formula within Underwriting Risk is the Analysis of Operations by Lines of Business (page 7 of the annual statutory financial statements). The page includes a buildup of underwriting gain/(loss), starting with net premium income, adding various other sources of revenue, then subtracting claims and administrative expenses. Some lines within the exhibit, including Fee-for-service and Risk revenue, are not broadly applicable, and the proportion of filers that utilize these fields is relatively small. Still, they often make up a material portion of revenue for those filers.

Those smaller components of the Analysis of Operations by Lines of Business have nuanced treatment within the current EFR formula that is likely not broadly understood. This nuanced treatment includes:

Nuance #1: Fee-for-service revenue is netted against incurred claims for Comprehensive Major Medical but not Medicare or Medicaid.

- The RBC instructions do not include the rationale for the distinction between lines of business.
- We do not see an intuitive rationale for the distinction and believe it may have been an inadvertent drafting error.

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

Nuance #2: The fee-for-service revenue netting can result in erratic net loss ratio experience for health plans with significant fee-for-service revenue levels.

- After investigating several instances of health plans reporting fee-for-service revenue, it appears that filer understanding of the field is mixed.
- Additionally, if health plans report a significant amount of fee-for-service revenue, the net loss ratio may look problematic:
    - For example, we observed a health plan with an approximately 100% gross loss ratio and a 140% net loss ratio; the gross loss ratio is more likely to resemble the "priced" loss ratio.
    - The risk charge is effectively applied to the net claims level, which is tantamount to a managed care credit discount of 1.0.

Nuance #3: Other Health Risk Revenue is included in the revenue calculation for Comprehensive Major Medical but not for Medicare or Medicaid.

- The RBC instructions do not include a rationale for the distinction between lines of business.
- We do not see an intuitive rationale for the distinction and believe it may have been an inadvertent drafting error.

Nuance #4: Aggregate write-in revenue (health and non-health) is excluded from the calculation.

- "Aggregate write-ins for other health care related revenues" is commonly populated and often represents pass-through revenue related to Aggregate write-ins for other hospital and medical (line 14), which is included in line 17.
- "Aggregate write-ins for other non-health care revenues" are infrequently populated and generally immaterial.

These nuances may need to be addressed within the existing formula but should be considered as part of any significant change to the EFR formula. For simplicity, one option to change the formula may be to use lines 7 and 17 for revenue and claims for each applicable line of business; however, we welcome additional suggestions based on feedback from the Working Group.

*****

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

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson, Health Solvency Subcommittee, Health Underwriting Risk Factors Analysis Work Group
American Academy of Actuaries

Cc: Crystal Brown, Senior Health RBC Specialist & Education Lead, Financial Regulatory Affairs, NAIC

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

CAPITAL ADEQUACY (E) TASK FORCE
WORKING AGENDA ITEMS FOR CALENDAR YEAR 2023

2023 #	Owner	2023 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 2022-16-CA (YE-2023)	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 2024 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	2	Year-end 2024 RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula. Work with the American Academy of Actuaries (Academy) to inquire through the NAIC on the reporting of the health care receivables to better understand why these	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal	

				receivables are being reported as such. With the intention to produce recommendations to improve instruction clarity or provide additional guidance.		(Year-End 2021) referred to the Blanks (E) Working Group	
~~X5~~	~~Health RBC WG~~	~~1~~	~~Year-end 2023 or later~~	~~Continue to review the: premium and reserve ratio in the Health Test Ad Hoc Group in the Health Test and review possible annual statement changes for reporting health business in the Life and P/C Blanks.~~	~~HRBCWG~~	~~Evaluate the applicability of the current Health Test in the Annual Statement instructions in today's health insurance market. Discuss ways to gather additional information for health business reported in other blanks.~~ ~~Referred Proposal 2022-06BWG to Blanks Working Group for exposure and consideration.~~	~~8/4/2018~~ ~~2/25/2022~~
X6	Health RBC WG	1	Year-end 2024 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 (Item 18 above) 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
X7	Health RBC WG	1	Year-end 2024 or later	Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
X8	Health RBC WG	2	Year-End 2024 or later	Consider the impact of COVID-19 and pandemic risk in the health RBC formula.	HRBCWG		7/30/2020
X9	Health RBC WG	3	Year-End 2025 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
~~X10~~	~~Health RBC WG~~	~~1~~	~~Year-End 2023 or later~~	~~Review and respond to the request from the Capital Adequacy (E) Task Force on the referral from the Restructuring Mechanisms (E) Subgroup for input regarding health runoff companies.~~	~~Capital Adequacy (E) Task Force~~	~~Response letter sent to Capital Adequacy 3/21/23~~	~~8/11/2022~~
New Items – Health RBC							