NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<tr><td>

DATE: 7-12-19

CONTACT PERSON: **Crystal Brown**

TELEPHONE: **816-783-8146**

EMAIL ADDRESS: **cbrown@naic.org**

ON BEHALF OF: **Health Risk-Based Capital (E) WG**

NAME: **Steve Drutz**

TITLE: **Chair**

AFFILIATION: **WA Office of the Insurance Commissioner**

ADDRESS: **5000 Capitol Blvd SE**

Tumwater, WA 98501

</td><td>

FOR NAIC USE ONLY

Agenda Item #__________

Year 2022

Changes to Existing Reporting [ ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ ]

Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date __________
[ ] Rejected Date __________
[ ] Deferred Date __________
[ ] Other (Specify) __________

</td></tr>
</table>

BLANK(S) TO WHICH PROPOSAL APPLIES

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

Anticipated Effective Date:____________________

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Annual Statement Test language

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

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

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:____________________

Other Comments:

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

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Health Annual Statement

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 Health Statement Threshold result should be considered a starting point for the domestic regulator in considering which blank the reporting entity should file to most appropriately reflect the data and risks associated with the type of business written. The 90% threshold could be used as a trigger; however, the domestic regulator may begin the discussion before the percentage threshold is ~~triggered~~reached. 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 Threshold calculation:**

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

The Health Statement Threshold calculation is designed to determine whether a reporting entity reports predominantly health lines of business. The purpose of this threshold is to identify a reporting entity writing predominantly health business (premium ratio of 90% or more) that should continue to file on a Health Statement and the associated Health RBC filing (if required) resulting in better disclosures and analysis of the health business being written. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts, which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, ~~and~~ Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC ~~and ASO~~ Business Reported as Revenue, and ~~Hospital Indemnity and Specified Disease~~Limited Benefit Plans ~~and Medicaid Pass-Through Payments~~. 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 should be excluded.

Core and non-core health business are split ~~is~~ to help guide the conversation between the reporting entity and the domiciliary regulator when determining which blank the reporting entity should file on. Core health business generally reflects business that is captured in more detail on the Health Blank, and therefore better captures the risks associated with writing that business. Non-core health business is generally not captured in as much detail on the Health Blank, and therefore might have less influence in determining which blank the reporting entity should file on.

Meeting the Threshold:

A reporting entity is deemed to have met the Health Statement ~~t~~Threshold if the values for the premium ratio in the Health Statement Threshold calculation (General Interrogatories, Part 2) equal or exceed 90% for both the reporting and prior year.

Not Meeting the Threshold:

Once the reporting entity has met the health threshold and is currently filing on the Health Statement (Health RBC filing), the health threshold calculation will be used to demonstrate that the insurer is still predominantly writing health business as defined above. If the premium ratio falls below 90% the company could still be viewed as writing predominantly health business and should continue to file on the Health Statement (and Health RBC Filing) but notify the domestic regulator as indicated below.

Variances from following these instructions:

If the reporting entity has consistently reported a premium ratio of 90% or greater in prior years and filed on the health blank but falls below the 90% premium ratio in the current year, the reporting entity shall apprise the domestic regulator and should advise of any changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the health annual statement and risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty annual statement blank and associated risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Threshold is submitted if a change in statement blank will be required in a following year.

Consideration may be given by the domestic regulator as to the break-out of business written on a percentage basis by the reporting entity. For example, the reporting entity wrote 90% core business and 9% non-core business in the first year in which it filed on the health blank and in the subsequent years, the writings went down to 80% core health business and 9% non-core health business. The domestic regulator should consider the reporting entity's overall business plan going forward to determine if the reporting entity should continue to report on the health blank and whether the health blank provides adequate disclosures and identification of significant risks associated with the type of business the company plans to write in the future.

The closer the reporting entity comes to a Health Premium Ratio of 90%, the more importance the split between core and non-core health business might have on the domiciliary regulator's decision as to which blank the reporting entity should file on. The more non-core health business drives the Health Premium Ratio result, the more the domiciliary regulator may consider other factors when determining which blank to file on, such as the reporting entity's future business plans, which blank the reporting entity is currently filing on, or what other lines of business the reporting entity writes. In making the blanks determination, the larger the percentage of core health business written, the more likely the Health Blank would better capture the risks and detailed health data that regulators use to make informed decisions in analysis and regulation of the reporting entity.

GENERAL INTERROGATORIES

PART 2 – HEALTH INTERROGATORIES

2. Health Threshold Calculation:

	1 Current Year	2 Prior Year
2.1 Core Health Business Premium Numerator	$	$
2.2 Non-Core Health Business Premium Numerator	$	$
2.3 Total Health Premium Numerator (2.1+2.2)	$	$
2.4 Total Premium Denominator	$	$
2.5 Core Health Business Premium Ratio (2.1/2.4)	$	$
2.6 Non-Core Health Business Premium Ratio (2.2/2.4)	$	$
2.7 Health Premium Ratio (2.3/2.4)	$	$

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, which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX,

Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans.~~Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue,~~ and ~~Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments.~~ 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 should be excluded.

All reporting entities should file the health threshold calculation.

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

Item	**Description**	**Reporting Year Annual Statement Data**	**Prior Year Annual Statement Data**
2.1	Core Health Business Premium Numerator	Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1. Comprehensive – Commercial – Individual (Column 2, in part) Comprehensive Commercial – Group (Column 2, in part) Comprehensive – Commercial – Minimum Premium (Column 2, in part) Medicaid – Title XXI (SCHIP) (Column 2, in part) TRICARE (Column 2, in part) Medicare Supplement (Column 3) Dental Only (Column 4) Vision Only (Column 5) Federal Employees Health Benefits Plan (FEHBP) (Column 6) Medicare – Title XVIII (Column 7) Medicaid - Title XIX (Column 8, in part) Medicaid – Title XIX – Pass Through Payments (Column 8, in part) Stand-Alone Medicare Part D (Column 9, in part) Other Stand-Alone RX Plans (Column 9, in part) (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies).	Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1. Comprehensive – Commercial – Individual (Column 2, in part) Comprehensive Commercial – Group (Column 2, in part) Comprehensive – Commercial – Minimum Premium (Column 2, in part) Medicaid – Title XXI (SCHIP) (Column 2, in part) TRICARE (Column 2, in part) Medicare Supplement (Column 3) Dental Only (Column 4) Vision Only (Column 5) Federal Employees Health Benefits Plan (FEHBP) (Column 6) Medicare – Title XVIII (Column 7) Medicaid - Title XIX (Column 8, in part) Medicaid – Title XIX – Pass Through Payments (Column 8, in part) Stand-Alone Medicare Part D (Column 9, in part) Other Stand-Alone RX Plans (Column 9, in part) (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies).

2.2	Non-Core Health Business Premium Numerator	Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1. Stop Loss (Column 9, in part) Limited Benefit Plans (Column 9, in part) ASC Business Reported as Revenue (Column 9, in part) Other Health (Column 9, in part) (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)	Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1. Stop Loss (Column 9, in part) Limited Benefit Plans (Column 9, in part) ASC Business Reported as Revenue (Column 9, in part) Other Health (Column 9, in part) (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)
2.3	Total Health Premium Numerator	Line 2.1 + 2.2	Line 2.1 + 2.2
2.4	Total ~~Health~~ Premium Denominator	Net Premium Income (Page 4, Line 2, Column 2) of the reporting year's annual statement.	Net Premium Income (Page 4, Line 2, Column 2) of the prior year's annual statement.
2.5	Core Health Business Premium Ratio	**2.1/2.4**	**2.1/2.4**
2.6	Non-Core Health Business Premium Ratio	**2.2/2.4**	**2.2/2.4**
2.7	Health Premium Ratio	**2.3/2.4**	**2.3/2.4**

Life Annual Statement

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 Health Statement Threshold should be considered a starting point for the domestic regulator in considering which blank the reporting entity should file to most appropriately reflect the data and risks associated with the type of business written. The 90% threshold could be used as a trigger; however, the domestic regulator may begin the discussion before the percentage threshold is ~~triggered~~reached. 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 Threshold Calculation:**

   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 Threshold calculation.

The purpose of the Health Statement Threshold calculation is to identify a reporting entity writing predominantly health lines of business (premium ratio of 90% or more), that should move and file on a Health Statement and the associated Health RBC filing (if required). The Health Statement provides for better disclosure and analysis of the health business written compared to other statement types. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans.~~Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments.~~ 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 should be excluded.

Core and non-core health business are split ~~is~~ to help guide the conversation between the reporting entity and the domiciliary regulator when determining which blank the reporting entity should file on. Core health business generally reflects business that is captured in more detail on the Health Blank, and therefore better captures the risks associated with writing that business. Non-core health business is generally not captured in as much detail on the Health Blank, and therefore might have less influence in determining which blank the reporting entity should file on.

Meeting the Threshold:

A reporting entity is deemed to have met the Health Statement Threshold if:

The values for the premium ratio in the Health Statement Threshold calculation equal or exceed 90% for both the reporting and prior year. The 90% threshold would include core and non-core health business, however, if the reporting entity falls below 90%, the domestic regulator may consider if there is a benefit to the reporting entity to file on the health blank.

If a reporting entity completes the Life, Accident and Health annual statement for the reporting year and b) meets the threshold of the Health Statement Threshold calculation (as described above), the reporting entity must begin completing the health statement with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Threshold and must also file the corresponding risk-based capital report and the life supplements for that year-end. (e.g. If the company passed the health threshold for year-end-2019 reporting, the company must begin filing the health blank with first quarter 2021). With permission from the domiciliary regulator, the reporting entity may begin filing on the Health Statement with the first quarter's statement for the first year following the reporting year (e.g. first quarter 2020).

Variances from following these instructions:

If the reporting entity has consistently reported a premium ratio below~~of~~ 90% ~~or greater~~in prior years and filed on the ~~health~~ life blank but ~~falls below~~exceeds the 90% premium ratio in the current year, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the ~~health~~ life annual statement and associated risk-based capital report or if the reporting entity should begin completing the ~~life, accident and health and fraternal or property and casualty~~ health annual statement form and risk-based capital report. The domestic regulator shall

notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Threshold is submitted if a change in the statement blank will be required in the following year.

To determine if the reporting entity should move from the life blank to the health blank consideration may be given by the domestic regulator as to the break-out of business written on a percentage basis by the reporting entity. For example, the reporting entity wrote 90% core business and 9% non-core business in the year-one and in the subsequent years, the writings went down to 80% core health business and 9% non-core health business. In this instance, the domestic regulator should consider the reporting entity's overall business plan going forward and determine if the reporting entity should move to report on the health blank as this would provide better disclosures and risks associated to this type of business.

The closer the reporting entity comes to a Health Premium Ratio of 90%, the more importance the split between core and non-core health business might have on the domiciliary regulator's decision as to which blank the reporting entity should file on. The more non-core health business drives the Health Premium Ratio result, the more the domiciliary regulator may consider other factors when determining which blank to file on, such as the reporting entity's future business plans, which blank the reporting entity is currently filing on, or what other lines of business the reporting entity writes. In making the blanks determination, the larger the percentage of core health business written, the more likely the Health Blank would better capture the risks and detailed health data that regulators use to make informed decisions in analysis and regulation of the reporting entity.

GENERAL INTERROGATORIES

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

2. Health Threshold Calculation:

	1 Current Year	2 Prior Year
2.1 Core Health Business Premium Numerator	$	$
2.2 Non-Core Health Business Premium Numerator	$	$
2.3 Total Health Premium Numerator (2.1+2.2)	$	$
2.4 Total ~~Health~~ Premium Denominator	$	$
2.5 Core Health Business Premium Ratio (2.1/2.4)	$	$
2.6 Non-Core Health Business Premium Ratio (2.2/2.4)	$	$
2.7 Health Premium Ratio (2.3/2.4)	$	$

PART 2 – LIFE ACCIDENT HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES 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 which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. ~~Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments.~~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 should be excluded.

All reporting entities should file the threshold calculation.

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

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Core Health Business Premium Numerator	**Health Premiums** values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1. Comprehensive – Commercial – Individual (Column 2, in part) Comprehensive Commercial – Group (Column 3, in part) Comprehensive – Commercial – Minimum Premium (Column 3, in part) Medicaid – Title XXI (SCHIP) (Column 2, in part) TRICARE (Column 3, in part) Medicare Supplement (Column 4) Dental Only (Column 6) Vision Only (Column 5) Federal Employees Health Benefits Plan (FEHBP) (Column 7) Medicare – Title XVIII (Column 8) Medicaid - Title XIX (Column 9, in part) Medicaid – Title XIX – Pass Through Payments (Column 9, in part) Stand-Alone Medicare Part D (Column 13, in part) Other Stand-Alone RX Plans (Column 13, in part) (excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)	**Health Premiums** values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1. Comprehensive – Commercial – Individual (Column 2, in part) Comprehensive Commercial – Group (Column 3, in part) Comprehensive – Commercial – Minimum Premium (Column 3, in part) Medicaid – Title XXI (SCHIP) (Column 2, in part) TRICARE (Column 3, in part) Medicare Supplement (Column 4) Dental Only (Column 6) Vision Only (Column 5) Federal Employees Health Benefits Plan (FEHBP) (Column 7) Medicare – Title XVIII (Column 8) Medicaid - Title XIX (Column 9, in part) Medicaid – Title XIX – Pass Through Payments (Column 9, in part) Stand-Alone Medicare Part D (Column 13, in part) Other Stand-Alone RX Plans (Column 13, in part) (excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)
2.2	Non-Core Health Premium Numerator	**Health Premiums** values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1. Stop Loss (Column 13, in part) Limited Benefit Plans (Column 13, in part)	**Health Premiums** values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1. Stop Loss (Column 13, in part) Limited Benefit Plans (Column 13, in part)

		ASC Business Reported as Revenue (Column 13, in part) Other Health (Column 13, in part) (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)	ASC Business Reported as Revenue (Column 13, in part) Other Health (Column 13, in part) (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)
2.3	Total Health Premium Numerator	**Line 2.1 + 2.2**	**Line 2.1 + 2.2**
2.4	Total ~~Health~~ Premium Denominator	Premium and Annuity Considerations (Page 4, Line 1) of the reporting year's annual statement	Premium and Annuity Considerations (Page 4, Line 1) of the prior year's annual statement
2.5	Core Health Premium Ratio	**2.1/2.4**	**2.1/2.4**
2.6	Non-Core Health Premium Ratio	**2.2/2.4**	**2.2/2.4**
2.7	Health Premium Ratio	**2.3/2.4**	**2.3/2.4**

Property/Casualty Annual Statement

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 Health Statement Threshold result should be considered a starting point for the domestic regulator in considering which blank the reporting entity should file to most appropriately reflect the data and risks associated with the type of business written. The 90% threshold could be used as a trigger; however, the domestic regulator may begin the discussion before the percentage threshold is ~~triggered~~reached. 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 Threshold Calculation:**

   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 Threshold calculation.

   The purpose of Health Statement Threshold calculation is to identify a reporting entity writing predominantly health lines of business (premium ratio of 90% or more), should move and file on a Health Statement and the associated Health RBC filing (if required). The Health Statement provides for better disclosure and analysis of the health business written compared to other statement types. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. ~~Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and~~

~~Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments.~~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 should be excluded.

Core and non-core health business are split ~~is~~ to help guide the conversation between the reporting entity and the domiciliary regulator when determining which blank the reporting entity should file on. Core health business generally reflects business that is captured in more detail on the Health Blank, and therefore better captures the risks associated with writing that business. Non-core health business is generally not captured in as much detail on the Health Blank, and therefore might have less influence in determining which blank the reporting entity should file on.

Meeting the Threshold:

A reporting entity is deemed to have met the Health Statement Threshold if:

The values for the premium ratio in the Health Statement Threshold calculation equal or exceed 90% for both the reporting and prior year. The 90% threshold would include core and non-core health business, however, if the reporting entity falls below 90%, the domestic regulator may consider if there is a benefit to the reporting entity to begin filing on the health blank.

If a reporting entity is a) completes the property and casualty annual statement for the reporting year and b) meets the threshold of the Health Statement Threshold (as described above), the reporting entity must begin completing the health statement with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Threshold and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end. (e.g. If the company passed the health threshold for YE-2019 reporting, the company must begin filing the health blank with first quarter 2021). With the permission of the domiciliary regulator, the reporting entity may begin filing on the health blank with the first quarters statement for the first year following the reporting year (e.g. first quarter 2020).

Variances from following these instructions:

If the reporting entity has consistently reported a premium ratio ~~of~~ below 90% ~~or greater~~ in prior years and filed on the ~~health~~ property/casualty blank but ~~falls below~~exceeds the 90% premium ratio in the current year, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the property/casualty~~health~~ annual statement and risk-based capital report or if the reporting entity should begin completing the ~~life, accident and health and fraternal or property and casualty~~health annual statement form and associated risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Threshold is submitted if a change in statement blank will be required in the following ear.

To determine if the reporting entity should move from the property/casualty blank to the health blank consideration may be given by the domestic regulator as to the break-out of business written on a percentage basis by the reporting entity. For example, the reporting entity wrote 90% core business and 9% non-core business in year-one and in the subsequent years, the writings went down to 80% core health business and 9% non-core health business. The domestic regulator should consider the reporting company's overall business plan going forward to determine if the reporting entity should move to report on the health blank and whether the health blank provides adequate disclosures and identification of significant risks associated with the type of business the reporting entity plans to write in the future.

The closer the reporting entity comes to a Health Premium Ratio of 90%, the more importance the split between core and non-core health business might have on the domiciliary regulator's decision as to which blank the reporting entity should

file on. The more non-core health business drives the Health Premium Ratio result, the more the domiciliary regulator may consider other factors when determining which blank to file on, such as the reporting entity's future business plans, which blank the reporting entity is currently filing on, or what other lines of business the reporting entity writes. In making the blanks determination, the larger the percentage of core health business written, the more likely the Health Blank would better capture the risks and detailed health data that regulators use to make informed decisions in analysis and regulation of the reporting entity.

GENERAL INTERROGATORIES
PART 2 – PROPERTY & CASUALTY INTERROGATORIES

2. Health Threshold Calculation:

	1 Current Year	2 Prior Year
2.1 Core Health Business Premium Numerator	$	$
2.2 Non-Core Health Business Premium Numerator	$	$
2.3 Total Health Premium Numerator (2.1+2.2)	$	$
2.4 Total ~~Health~~ Premium Denominator	$	$
2.5 Core Health Business Premium Ratio (2.1/2.4)	$	$
2.6 Non-Core Health Business Premium Ratio (2.2/2.4)	$	$
2.7 Health Premium Ratio (2.3/2.4)	$	$

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 which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. ~~Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments.~~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 should be excluded.

All reporting entities should file the threshold calculation.

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

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Core Health Business Premium Numerator	**Health Premiums** values listed in the statement value column (Column 1) of the reporting year's P&C RBC report: Comprehensive – Commercial – Individual Comprehensive Commercial – Group	**Health Premiums** values listed in the statement value column (Column 1) of the reporting year's P&C RBC report: Comprehensive – Commercial – Individual Comprehensive Commercial – Group

		Comprehensive – Commercial – Minimum Premium Medicaid – Title XXI (SCHIP) TRICARE Medicare Supplement Dental Only Vision Only Federal Employees Health Benefits Plan (FEHBP) Medicare – Title XVIII Medicaid - Title XIX Medicaid – Title XIX – Pass Through Payments Stand-Alone Medicare Part D Other Stand-Alone RX Plans (excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)	Comprehensive – Commercial – Minimum Premium Medicaid – Title XXI (SCHIP) TRICARE Medicare Supplement Dental Only Vision Only Federal Employees Health Benefits Plan (FEHBP) Medicare – Title XVIII Medicaid - Title XIX Medicaid – Title XIX – Pass Through Payments Stand-Alone Medicare Part D Other Stand-Alone RX Plans (excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)
2.2	Non-Core Health Premium Numerator	**Health Premiums** values listed in the statement value column (Column 1) of the reporting year's Life RBC report: Stop Loss Limited Benefit Plans ASC Business Reported as Revenue Other Health (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)	**Health Premiums** values listed in the statement value column (Column 1) of the reporting year's Life RBC report: Stop Loss Limited Benefit Plans ASC Business Reported as Revenue Other Health (in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)
2.3	Total Health Premium Numerator	Line 2.1 + 2.2	Line 2.1 + 2.2
2.4	Total ~~Health~~ Premium Denominator	Premiums earned ~~and Annuity Considerations~~ (Page 4, Line 1) of the reporting year's annual statement	Premiums earned ~~and Annuity Considerations~~ (Page 4, Line 1) of the prior year's annual statement
2.5	Core Health Premium Ratio	**2.1/2.4**	**2.1/2.4**
2.6	Non-Core Health Premium Ratio	**2.2/2.4**	**2.2/2.4**
2.7	Health Premium Ratio	**2.3/2.4**	**2.3/2.4**