

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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

BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|---|---|--------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> 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.

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.)

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

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	<p>Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health:</p> <p><u>The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus</u></p> <p><u>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.</u></p>	<p><u>Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health:</u></p> <p><u>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.</u></p> <p>Health Premium values listed in the statement value column (Column 1) of the reporting year's Life RBC report:</p> <p>Individual Lines: Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision</p> <p>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</p>
2.2	Premium Denominator	<p>Premium and Annuity Considerations (Page 4, Line 1) of the reporting year's annual statement <u>Analysis of Operations by Lines of Business – Summary, Column 1, Line 1 of the reporting year's annual statement.</u></p>	<p><u>Analysis of Operations by Lines of Business – Summary, Column 1, Line 1</u> Premium and Annuity Considerations (Page 4, Line 1) of the prior year's annual statement</p>
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 <u>Total (Net) Unearned Premiums</u> (Line 17) <u>or the reporting year's annual statement, and Future Contingent Benefits (Line 4)</u>	without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11 <u>(excluding Dread Disease, Disability Income and Long-Term Care)</u>) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns <u>10, 11, 12 and Dread Disease included in Column 13</u>) for <u>Unearned Premiums Total (Net) (Line 17) of the prior year's annual statement, and Future Contingent Benefits (Line 4)</u>
2.5	Reserve Denominator	Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2 <u>Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4</u>) 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 (<u>Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4</u>) 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 89 plus Line 1 plus Line 2 , Column 913 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 139 (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 139) 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.)

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

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	<p>Health Premium values listed in the Net Premiums Written<u>Earned During Year</u> column (Column 46) of the reporting year's U&I Part 1B:</p> <p>Lines 13.1 and 13.2</p> <p>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</p> <p>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</p> <p>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<u>include only Medicare Part D and Stop Loss and Minimum Premium</u>)</p>	<p>Health Premium values listed in the Premiums Earned During Year column (Column 4) of the reporting year's U&I Part 1:</p> <p><u>Lines 13.1 and 13.2</u></p> <p><u>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</u></p> <p><u>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</u></p> <p><u>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)</u></p> <p>Health Premium values as listed in the statement value column (Column 1) of the prior year's P&C RBC report:</p> <p><u>Individual Lines</u> Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision</p> <p><u>Group Lines</u> 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</p>
2.2	Premium Denominator	Premiums Earned (Page 4, Line 1) of the reporting year's annual statement <u>Underwriting and Investment Exhibit, Part 1, Column 4, Line 35</u>	<u>Underwriting and Investment Exhibit, Part 1, Column 4, Line 35</u> 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) (<u>excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care</u>), <u>Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)</u>) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (<u>excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care</u>), <u>Line 15.9 in part (include only Medicare Part D and Stop Loss and</u>

		year's annual statement.	<u>Minimum Premium))</u> 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).