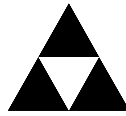

AMERICAN ACADEMY *of* ACTUARIES

Supplement to the

Report of the American Academy of Actuaries' Long Term Care Risk Based Capital Work Group

To the

NAIC Capital Adequacy Task Force

September 2004

The American Academy of Actuaries is the public policy organization for 15,000 actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the actuarial profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

Attached are proposed changes to the Life RBC Formula and Instructions and the Health RBC Formula and Instructions to implement new factors for Long-Term Care Insurance consistent with the June 2004 Report.

The proposed changes allow for four aspects that were not part of the Academy's June recommendations as discussed below.

1. Tax Adjustment for Life Formula

   The Life formula has an overall adjustment for taxes, calculated in LR026. Since the factors in the Academy report were developed on an after-tax basis, they must be adjusted to a pre-tax basis to work properly in the life formula. The factors for the life formula are the after tax factors in the Academy report divided by 0.65 (1 minus a tax rate of 35%).

2. Factor Difference for Noncancelable versus Guaranteed Renewable LTC Premiums

   The current formulas apply a factor of 35% to the first $50 million of NC premium but only 25% to the first $50 million[1] of GR premium. A factor of 15% applies to all amounts in excess of $50 million regardless of the renewal category. In the Academy's June recommendation, there are no factors based on premium and the factors applying to incurred claims do not differentiate between NC and GR.

   While there is very little NC premium in force, and we know of no company currently selling NC, the possibility exists that NC could be written. As a result, this proposed formula includes a "Rate Risk" component of 10% that applies to all NC premiums.

3. Averaging Incurred Claims to Reduce Variability

   The Academy report in subsection 2 of Section 8.4 notes the value of averaging incurred claims over several years:

   > "Another concern is that the annual incurred claims are subject to greater variability than premiums. If claims are high in any year, so will risk based capital for that year. Both will have the unintended effect of exacerbating unfavorable experience.
   >
   > "… the Group recognized that annual incurred claims might not be as stable as premiums. An average of the most recent three-year incurred claims would be a more stable factor. To give greater effect to the current year's incurred claims, the averaging method could increase the weight for this year relative to the prior two while still increasing stability of RBC.

   The proposed changes to the formula use the experience of the last three years to determine an average loss ratio. This average loss ratio multiplied by current year earned premium is called Adjusted LTC Claims for RBC. We believe this result is a better reflection of current exposure than the direct average of incurred claims. Other approaches to averaging could be used if the NAIC does not wish to adopt this approach.

[1] The factor is applied to the residual of the first $50 million if the company has any NC premium.

4. Full Adoption of New Method or Transition

The NAIC may wish to adopt the factors applied to incurred claims in part and continue to use RBC factors applied to earned premiums for the other part. Alternatively, the NAIC may wish to adopt some period of transition as suggested in the Academy's report. Section 8.5 of that report discusses transition:

> "Any change in the risk based capital formula will have an impact on a company's capital management plan. The Life Risk Based Capital Subgroup may want to consider the following alternatives for transition to a new formula:
>
> - Use a grading of the new formula and the current formula. For example, over a 5-year period, the risk based capital for the first year would be 80% of the current formula and 20% of the new formula. For the second year, it will be 60% of the current formula and 40% of the new formula, and so on. This approach also provides a gradual transition from a premium-based formula to a claim-based formula.
>
> - Set the effective date of the new formula to be 3 years from the adoption date. This allows companies the time to plan and to adjust to the new formula.
>
> - Permit voluntary adoption of the new formula over the next 3 years."

The proposed changes to the formulas allow for the continued use of the current factors applied to premiums as well as the new factors applied to incurred claims. The proportions are designated A% for premium-based RBC and (1-A%) for claims-based RBC. The value of A can be constant (i.e. less than full adoption), or it could change over three to five years (i.e. transition).

If the NAIC wishes to adopt the Academy's June recommendations in a different manner or further refine any of the above items, the Academy would be happy to offer assistance in making the necessary changes to the attached.

Attachments:

Life RBC Formula Changes – (download Excel file)

Changes are to LR016 and the addition of a new sheet LR0xx

Life RBC Instructions – (page 4)

Changes to separate DI and LTC instructions within "Health Premiums" section

Health RBC Formula Changes – (download Excel file)

Changes to XR014

Health RBC Instructions – (page 30)

Changes to "Other Underwriting Risk" section

HEALTH PREMIUMS and HEALTH CLAIM RESERVES *(click here to return to attachment list)*

LR016, LR0xx and LR020

Basis of Factors

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

Medical Insurance Premium

The business is subdivided by product into three categories for individual coverages and four categories for group and credit coverages depending on the risk related to volatility of claims. The factors were developed from a model that determines the minimum amount of surplus needed to protect the company against a worst case scenario for each type of coverage. The results of the model were then translated into either a uniform percentage or a two-tier formula to be applied to premium. The two-tier formula reflects the decreased risk of a larger in force block. The formula includes several changes starting in 1998 for some types of health insurance. These changes add several additional worksheets and are designed to keep the RBC amounts for health coverage consistent regardless of the RBC formula used. If the company has Comprehensive Medical business, Medicare Supplement or Dental business, it will be directed to these additional worksheets. The instructions for including paid health claims in the various categories of the Managed Care Discount Factor Calculation can be found in the instructions to LR019 Underwriting Risk – Managed Care Credit. Appendix 2 of these instructions lists commonly used health insurance terms. If the company has any of the three mentioned types of Medical Insurance, it will also be required to complete additional parts of the formula for C-3 Health Credit Risk and C-4 Health Administrative Expenses Risk portion of the Business Risk.

Disability Income ~~and Long-Term Care Insurance (LTC)~~ Premium

Prior to 2001, the individual disability income factors were based on models of the disability risk completed by several companies with significant experience in this line. The group long-term disability income risk was modeled based on methodology similar to that used by one of the largest writers of this business. The pricing risk was addressed principally as the delayed reaction to increases in incidence of new claims and to the lengthening of claims from slower recoveries than assumed. ~~For long-term care, the experience needed to develop unique factors is still under development. Starting in 1999, and until new factors are developed for LTC, new lines specific to long-term care premiums have been added and use the original disability income factors.~~

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

Long Term Care Insurance Premium

Prior to 2005, factors equal to the original disability income were used. Starting in 2005, factors based on LTC experience are being **[partially]** used until **200x** while the existing factors will be eliminated. The difference in the factor for Noncancellable LTC versus other LTC has been retained as a Rate Risk factor applied to the NC premium (up to $50,000,000). The Morbidity Risk is partially applied directly to premium with a higher factor applied to amounts up to $50,000,000 and a lower factor applied to premiums in excess of $50,000,000. In addition, the earned premiums and incurred claims for the last three years are used to determine an average loss ratio **[details to be spelled out]**. This average loss ratio times the current year's premium is called Adjusted LTC Claims for RBC. A higher factor is applied to claims up to $35,000,000 and a lower factor is applied to claims above $35,000,000. For 2005, the RBC amounts for morbidity risk are weighted **A%** for the premium component and **(1-A)%** for the claims component.

Claim Reserves

Additional risk-based capital of 5 percent of claim reserves for both individual and group and credit is required to recognize the risk of the level of recoveries and other claim terminations falling below that assumed in the development of claim reserves. However, claims reserves for Workers Compensation Carve-out are excluded from this charge and are separately assessed risk-based capital on page LR018 Underwriting Risk – Other, Line (5); reserves entered for this exclusion should be reported in net balance sheet reserves in Schedule P, Part 1 of the Workers Compensation Carve-Out Supplement.

Pre-Tax and Post-Tax Factors

The formula uses pre-tax factors for all types of health insurance. Because many insurers of some types of health insurance write very little other business, it was determined that there would be no difference between pre-tax and post-tax factors except where substantial investment income is assumed as part of the product pricing. Thus, for disability income ~~and long-term care insurance,~~ the pre-tax factors on pages 26-28 and in LR0xx for long term care will be adjusted to post-tax by applying a tax-effect change to RBC in LR026. For reasons of practicality and simplicity, credit disability is included with other disability income and adjusted to post-tax. The pre-tax RBC values for other types of health insurance will not be adjusted.

Specific Instructions for Application of the Formula

The total of all earned premium categories LR016 Health Premiums, Line (28), Column (1) should equal the total in Schedule H, Line 2, Column 1 of the Annual Statement. Earned premium for each of these coverages should be from underlying company records. Earned premium may be reported in Schedule H for Administrative Services Contracts (ASC) and/or the Federal Employees Health Benefit Plan (FEHBP) and/or Worders Compensation Carve-Out which are included in order that Line (28) will equal the total in Schedule H. As such, there is no RBC factor applied to any premium reported on lines (14), (25) or (26). For some of the coverages, two tier formulas apply. The calculations for these coverages shown below will not appear on the RBC filing software but will automatically be calculated by the software.

<u>Line (1)</u>
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (1) Line (1.1).

<u>Line (2)</u>
Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (2) Line (1.1).

<u>Line (3)</u>
Health premiums for dental or vision coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (3) Line (1.1).

<u>Line (4) and Line (11)</u>
There is a factor for certain types of Limited Benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5 percent) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

<u>Line (5) and Line (12)</u>
The factor for Accidental Death and Dismemberment (AD&D) insurance (where a single lump sum is paid) depends on several items:

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

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

<u>Line (6) and Line (13)</u>
The factor for Other Accident coverage provides for any accident-based contingency other than those contained in Lines (5) or (12). For example, this line should contain all the premium for policies that provide coverage for accident-only disability or accident-only hospital indemnity. The premium for policies that contain AD&D in addition to other accident-only benefits should also be shown on this line.

Line (7)
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (1) Line (1.2).

Line (8)
Health premiums for dental or vision coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (3) Line (1.2).

Line (10)
Health premiums for Medicare supplement written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (2) Line (1.2).

Lines (15) through (24)
Disability income premiums are to be separately entered depending upon category (Individual and Group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.) For Group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). For long-term care insurance, premiums are reported separately for Individual noncancellable, Individual (other than NC) and Group LTCI. The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of Group and Credit are combined in a different category from Individual. For long-term care, all types (Individual and Group) are combined.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g. Line 15) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g. a), b) etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

			Annual Statement Source	(1) Statement Value	Factor	(2) RBC Requirement
		Disability Income Premium				
Line (15)		Noncancellable Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part	______		
	a)	First $50 Million Earned Premium of Line (15)	Company Records	______	X 0.539 =	______
	b)	Over $50 Million Earned Premium of Line (15)	Company Records	______	X 0.231 =	______
	c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (15) + b) of Line (15), Column (2)			______
Line (16)		Other Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part	______		

	a)	Earned Premium in Line (16) [up to $50 million less premium in a) of Line (15)]	Company Records	______	X 0.385 =	______
	b)	Earned Premium in Line (16) not included in a) of Line (16)	Company Records	______	X 0.108 =	______
	c)	Total Other Disability Income - Individual Morbidity	a) of Line (16) + b) of Line (16), Column (2)			______
Line (17)		Disability Income - Credit Monthly Balance	Earned Premium included in Schedule H, Part 1, Line 2, in part	______		
	a)	First $50 Million Earned Premium of Line (17)	Company Records	______	X 0.308 =	______
	b)	Over $50 Million Earned Premium of Line (17)	Company Records	______	X 0.046 =	______
	c)	Total Disability Income - Credit Monthly Balance	a) of Line (17) + b) of Line (17), Column (2)	______		______
Line (18)		Disability Income – Group Long Term	Earned Premium included in Schedule H, Part 1, Line 2, in part	______		
	a)	Earned Premium in Line (18) [up to $50 million less premium in a) of Line (17)]	Company Records	______	X 0.231 =	______
	b)	Earned Premium in Line (18) not included in a) of Line (18)	Company Records	______	X 0.046 =	______
	c)	Total Disability Income – Group Long Term	a) of Line (18) + b) of Line (18), Column (2)	______		______
Line (19)		Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part. This amount to be reported on Health Premiums, Line (19)	______		
	a)	Additional Reserves for Credit Disability Plans	LR016 Health Premiums Column (1) Line (29)	______		
	b)	Additional Reserves for Credit Disability Plans, Prior Year	LR016 Health Premiums Column (1) Line (30)	______		
	c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (19) - a) of Line (19) + b) of Line (19)	______		
	d)	Earned Premium in c) [up to $50 million less premium in a) of Line (17) + a) of Line (18)]	Company Records	______	X 0.231 =	______
	e)	Earned Premium in c) of Line (19) not included in d) of Line (19)	Company Records	______	X 0.046 =	______
	f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (19) + e) of Line (19), Column (2)			______

Line		Description	Source	Amount	Factor	Result
<u>Line (20)</u>		Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part	______		
	a)	Earned Premium in Line (20) [up to $50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19)]	Company Records	______	X 0.154 =	______
	b)	Earned Premium in Line (20) not included in a) of Line (20)	Company Records	______	X 0.046 =	______
	c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (20) + b) of Line (20), Column (2)	______		______
<u>Line (21)</u>		Disability Income – Group Short Term	Earned Premium included in Schedule H, Part 1, Line 2, in part	______		
	a)	Earned Premium in Line (21) [up to $50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19) + a) of Line (20)]	Company Records	______	X 0.077 =	______
	b)	Earned Premium in Line (21) not included in a) of Line (21)	Company Records	______	X 0.046 =	______
	c)	Total Disability Income – Group Short Term	a) of Line (21) + b) of Line (21), Column (2)	______		______
~~Line (22)~~		~~Noncancellable Long-Term Care – Individual Morbidity~~	~~Earned Premium (Schedule H, Part 1, Line 2, in part) first 50 Million~~	______	~~X 0.539 =~~	______
			~~Earned Premium (Schedule H, Part 1, Line 2, in part) over 50 Million~~	______	~~X 0.231 =~~	______
			~~Total (Amounts reported on Health Premiums, Line (22))~~	______		______
~~Line (23)~~		~~Other Long-Term Care – Individual Morbidity~~	~~Earned Premium (Schedule H, Part 1, Line 2, in part) first 50 Million less the premium in line (22) up to 50 million~~	______	~~X 0.385 =~~	______
			~~Earned Premium (Schedule H, Part 1, Line 2, in part) not included above subject to the 0.385 factor~~	______	~~X 0.231 =~~	______
			~~Total (Amounts reported on Health Premiums, Line (23))~~	______		______

~~Line (24)~~	~~Long-Term Care - Group Morbidity~~	~~Earned Premium (Schedule H, Part 1, Line 2, in part) first 50 Million less the premium in line (22) or (23) up to 50 million~~		~~X 0.385 =~~	
		~~Earned Premium (Schedule H, Part 1, Line 2, in part) not included above subject to the 0.385 factor~~		~~X 0.231 =~~	
		~~Total (Amounts reported on Health Premiums, Line (24))~~			

Line (26)
Premiums for Workers Compensation Carve-Out are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The RBC Requirement is assessed on these premiums can be found on page LR018 Underwriting Risk – Other, Line (4).

Line (27)
It is anticipated that most health premium will have been included in one of the other lines. In the event that some coverage does not fit into any of these categories, the "Other Health" category continues the RBC factor from the 1998 and prior formula for Other Limited Benefits Anticipating Rate Increases.

UNDERWRITING RISK – EXPERIENCE FLUCTUATION RISK

LR017

The underwriting risk generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this worksheet comes from LR019 Underwriting Risk - Managed Care Credit page.

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

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

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

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

or

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

Line (1) through Line (18)

There are three lines of business used in the Life RBC formula for calculating the RBC requirement in this worksheet. Other health coverages will continue to use the factors on LR016 Health Premiums. The three lines of business are: Column (1) Comprehensive Medical and Hospital, Column (2) Medicare Supplement and Column (3) Dental & Vision. The other column of LR017 is not to be used. Each of the three lines of business has its own column in the Underwriting Risk - Experience Fluctuation Risk table (For life RBC, Column (4) Other is not used). The categories listed in the columns of this worksheet include premiums plus all risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

Comprehensive Medical & Hospital

Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC) or administrative services only (ASO) contracts. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) business which is reported on LR018 Underwriting Risk – Other Line (3). The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000.

Medical Only (non-hospital professional services)

Include in Comprehensive Medical.

Medicare Supplement

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

Dental & Vision

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

Other Health Coverages

Include in the appropriate line on page LR016 Health Premiums.

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

Line (1) Premium

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

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

Line (2) Title XVIII Medicare
This is the earned amount of money charged by the insurer (net of reinsurance) for Medicare risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicare subscribers.

Line (3) Title XIX Medicaid
This is the earned amount of money charged by the insurer for Medicaid risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicaid subscribers.

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

Line (5) Underwriting Risk Revenue
The sum of Lines (1.3) through (4).

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

Column (1) claims come from Schedule H Part 5 Column 1 Line 13 less the amounts reported as incurred claims for Administrative Services Contracts (ASC) in Line (51) of LR025 Business Risk and Federal Employee Health Benefit Plan (FEHBP) in Line (3) of LR018 Underwriting Risk – Other. Note that Medicare supplement claims could be double counted if included in Column 1 of Schedule H Part 5 rather than Column 3. Column (2) for Medicare Supplement should be net of reinsurance, the same as the other columns. Column (2) for Medicare Supplement should use the direct claims from General Interrogatories Part 2 Line 1.5 after adjusting them for reinsurance. Column (3) dental claims come from Schedule H Part 5 Column 2 Line 13.

Line (7) Fee-for-Service Offset

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

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

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

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

	$0 - $3 Million	$3-$25 Million	Over $25 Million
Comprehensive Medical	0.150	0.150	0.090
Medicare Supplement	0.105	0.067	0.067
Dental	0.120	0.076	0.076

Line (11) Base Underwriting Risk RBC
Line (5) x Line (9) x Line (10.3).

Line (12) Managed Care Discount
A managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claims payments attributable to the managed care arrangements. The discount factor is from Line (11) of LR019 Underwriting Risk - Managed Care Credit.

Line (13) Base RBC After Managed Care Discount
Line (11) x Line (12).

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

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

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

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

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

Examples of the calculation are presented below:

EXAMPLE 1 (Insurer provides Comprehensive Care):

Highest Attachment Point (Retention)	$100,000	
Reinsurance Coverage	90% of $500,000 in excess of $100,000	
Maximum reinsured coverage	$600,000 ($100,000 + $500,000)	
Maximum Retained Risk =	$100,000	deductible
	+$150,000	($750,000 - $600,000)
	+$50,000	(10% of $500,000 coverage layer)
	=$300,000	

EXAMPLE 2 (Insurer provides Comprehensive Care):

Highest Attachment Point (Retention)	$75,000	
Reinsurance Coverage	90% of $1,000,000 in excess of $75,000	
Maximum reinsured coverage	$1,075,000 ($75,000 + $1,000,000)	
Maximum Retained Risk =	$75,000	deductible
	+ 0	($750,000 - $1,075,000)
	+$67,500	(10% of $675,000 coverage layer)
	=$142,500	

Line (16) Alternate Risk Charge

Twice the amount in Line (15), subject to a maximum of $1,500,000 for comprehensive medical and $50,000 for the other lines.

Line (17) Net Alternate Risk Charge
The largest value from Line (16) is retained for that column in line (17) and all others are ignored.

Line (18) Net Underwriting Risk RBC
The maximum of Line (14) and Line (17).

UNDERWRITING RISK - OTHER

LR018

Lines (1) and (2)
In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when insurers guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business which include a medical trend risk (i.e., Comprehensive Medical, Medicare Supplement, Dental, Stop-Loss and Minimum Premium and Other Limited Benefits Anticipating Rate Increases). Premiums entered should be the earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

Line (3)
A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the federal employees health benefit program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code. Claims incurred are multiplied by 2 percent to determine total underwriting RBC on this business.

Lines (4) through (6)
Separate risk factors have been established for Workers Compensation Carve-Out business. A factor of 0.364 is applied against net premiums written as shown in the Workers Compensation Carve-Out Supplement. A factor of 0.347 is applied against total net losses and expenses unpaid as shown in Schedule P, Part 1 of the Workers Compensation Carve-Out Supplement. These factors are taken from the industry component used in the P&C RBC formula for workers compensation reinsurance assumed.

A factor of 0.060 is applied against reinsurance recoverable balances on reinsurance ceded to non-affiliated companies (except certain pools), as shown in Schedule F, Part 2 of the Workers Compensation Carve-Out Supplement. This factor represents the difference between the total charge for reinsurance recoverables in the P&C RBC formula and the effective post-tax factor already reflected in the Life & Health formula on page LR014 Reinsurance. The following types of cessions are exempt from this charge: cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs, cessions to qualifying Voluntary Market Mechanism Pools and Associations (where there is joint liability for pool members along with adequate spread of risk, such that the risk of the pool collapsing from one or a few individual member solvency problems is immaterial), and cessions to U.S. Parents, Subsidiaries, and Affiliates. Qualifying Voluntary Market Mechanism Pools must be manually entered on Line (6.1) to receive the exemption.

UNDERWRITING RISK - MANAGED CARE CREDIT

LR019

This worksheet LR019 Underwriting Risk - Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical or Dental business or all of them. Line (1) will be filled in as the balancing item if any of Lines (2) through (8) are entered (and then Line (9) will be required).

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

There are currently five levels of managed care that are used in the RBC formulas, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

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

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

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

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

- Fee for service (charges).
- Discounted fee for service (based upon charges).
- Usual Customary and Reasonable (UCR) Schedules.
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).

- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
- Claim payments not included in other categories.

Line (2)

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

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

Line (3)

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

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

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

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

† These are amounts due before deducting withhold or paying bonuses
‡ These are actual payments made after deducting withhold or paying bonuses

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

Line (4)

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

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

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

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

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

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

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

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

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

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

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

Enter the amount of medical expense capitations paid to non-regulated intermediaries which are not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition in Appendix 2 for Intermediary but not Regulated Intermediary. In

those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions either within or beyond a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

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

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

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

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

Line (10)
Weighted Average Managed Care Discount – This amount is calculated by dividing the total weighted claims (Line (9) Column (2)) by the total claim payments (Line 9 Column (1)).

Line (11)
Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. It is one minus the Weighted Average Managed Care Discount (Line (10)).

Lines (12) through (18)

Lines (12) through (18) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (12)

Enter the prior year's actual withhold and bonus payments.

Line (13)
Enter the prior year's withholds and bonuses that were available for payment in the prior year.

Line (14)
Divides Line (12) by Line (13) to determine the portion of withholds and bonuses that were actually returned in the prior year.

Line (15)
Equal to Line (13) and is automatically pulled forward.

Line (16)
Claims payments that were subject to withholds and bonuses in the prior year. Equal to Line (3) + Line (4) of LR019 Underwriting Risk–Managed Care Credit FOR THE PRIOR YEAR.

Line (17)
Divides Line (15) by Line (16) to determine the average withhold rate for the prior year.

Line (18)
Multiplies Line (14) by Line (17) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the insurer's withhold/bonus program in the prior year.

LIFE INSURANCE

LR021

Basis of Factors

The factors chosen represent surplus needed to provide for excess claims over expected, both from random fluctuations and from inaccurate pricing for future levels of claims. For a large number of trials, each insured either lives or dies based on a "roll of the dice" reflecting the probability of death from both normal and excess claims. The present value of the claims generated by this process, less expected claims, will be the amount of surplus needed under that trial. The factors chosen under the formula produce a level of surplus at least as much as needed in 95 percent of the trials.

The model was developed for portfolios of 10,000, 100,000 and one million lives, and it was found that the surplus needs decreased with larger portfolios, consistent with the law of large numbers.

Net amount at risk was chosen as a base because expected claims are difficult to calculate on a consistent basis from company to company.

Specific Instructions for Application of the Formula

Annual Statement reference is for the total net amount at risk for the category (e.g., Individual & Industrial is one category). The net amount at risk is then further broken down by size as in a tax table to reflect the decrease in risk for larger blocks of life insurance. This breakdown will not appear on the RBC filing software or on the printed copy as the application of factors to amounts in force is completed automatically. The calculation is as follows:

Line (8)	Individual & Industrial	(1) Statement Value	Factor	(2) RBC Requirement
	First 500 Million	________	X 0.0023 =	________
	Next 4,500 Million	________	X 0.0015 =	________
	Next 20,000 Million	________	X 0.0012 =	________
	Over 25,000 Million	________	X 0.0009 =	________
	Total Individual and Industrial Net Amount at Risk	________		________

Line (20)	Group & Credit	Statement Value	Factor	RBC Requirement
	First 500 Million	________	X 0.0018 =	________
	Next 4,500 Million	________	X 0.0012 =	________
	Next 20,000 Million	________	X 0.0009 =	________
	Over 25,000 Million	________	X 0.0008 =	________
	Total Group and Credit Net Amount at Risk (less FEGLI & SGLI in force)	________		________

All amounts should be entered as required. The risk-based capital software will calculate the RBC requirement for individual and industrial and for group and credit.

PREMIUM STABILIZATION RESERVES

LR022

Basis of Factors

Premium stabilization reserves are funds held by the company in order to stabilize the premium a group policyholder must pay from year to year. Usually experience rating refunds are accumulated in such a reserve so that they can be drawn upon in the event of poor future experience. This reduces the insurers risk.

For group life and health insurance, 50 percent of premium stabilization reserves held in the Annual Statement as a liability (not as appropriated surplus) are permitted as an offset up to the amount of risk-based capital. The 50 percent factor was chosen to approximate the portion of premium stabilization reserves that would be an appropriate offset if the formula were applied on a contract by contract basis, and the reserve offset was limited to the amount of risk-based capital required for each contract. Life and health coverages are aggregated due to many companies combining these coverages.

Specific Instructions for Application of the Formula

There is some variance for reporting liabilities that are appropriately considered premium stabilization reserves. These possible Annual Statement sources are noted.

The sum of these various types of premium stabilization reserves equals the preliminary premium stabilization reserve credit. The final premium stabilization reserve credit is limited to the risk-based capital previously calculated. Since the limitation is applied on an aggregate basis, there is no need to differentiate the premium stabilization reserve between life and health.

HEALTH CREDIT RISK

LR024

Basis of Factors

The Health Credit Risk is an offset to some portions of the managed care discount factor. Since the managed care discount factor assumes that health risks are transferred to health care providers through fixed prepaid amounts, the Health Credit Risk compares these capitation payments to security the company holds. To the extent that the security does not completely cover the credit risk of capitated payments, a risk charge is applied to the exposed portion.

Capitations – Line (1) through Line (6)

Credit risk arises from capitations paid directly to providers or to intermediaries. The risk is that the company will pay the capitation but will not receive the agreed-upon services and will encounter unexpected expenses in arranging for alternative coverage. The credit risk RBC requirement for capitations paid directly to providers is 2 percent of the amount of capitations reported as paid claims in LR019 Underwriting Risk – Managed Care Credit. This amount is roughly equal to two weeks of paid capitations.

However, an insurer can also make arrangements with its providers that mitigate the credit risk, such as obtaining acceptable letters of credit or withholding funds. Where the insurer obtains these protections for a specific provider, the amount of capitations paid to that provider are exempted from the credit risk charge. A separate worksheet is provided to calculate this exemption, but an insurer is not obligated to complete the worksheet.

The credit risk RBC requirement for capitations to intermediaries is 4 percent of the capitated payments reported as paid claims in LR019 Underwriting Risk – Managed Care Credit. However, as with capitations paid directly to providers, the regulated insurer can eliminate some or all of the credit risk that arises from capitations to intermediaries by obtaining acceptable letters of credit or withheld funds.

Specific Instructions for Application of the Formula

Line (1) - Total Capitations Paid Directly to Providers.

This is the amount reported in LR019 Underwriting Risk–Managed Care Credit Column (1) Line (5)

Line (2) - Less Secured Capitations to Providers.

This includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 8 percent of annual claims paid to the provider. If lesser protection is provided (e.g., an acceptable letter of credit equal to 2 percent of annual claims paid to that provider), then the amount of capitation is prorated. The exemption is calculated separately for each provider and intermediary. A sample worksheet to calculate the exemption is shown in Figure (10).

Line (3) – Net Capitations to Providers Subject to Credit Risk Charge.

Line (1) minus Line (2).

Line (4) - Total Capitations to Intermediaries.

From Line (6) and Line (7) of LR019 Underwriting Risk–Managed Care Credit, this includes all capitation payments to intermediaries.

Line (5) - Less Secured Capitations to Intermediaries.

This includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 16 percent of annual claims paid to the provider. If lesser protection is provided (e.g., an acceptable letter of credit equal to 5 percent of annual claims paid to that provider), then the amount of capitation is prorated. The exemption is calculated separately for each provider and intermediary. A sample worksheet to calculate the exemption is shown in Figure (11).

(Figure 10)

Capitations Paid Directly to Providers

		(A)	(B)	(C)	(D)	(E)
					=(B+C)/A	=A*Min(1,D/8%)
Number	Name of Provider	Paid Capitations During Year	Letter of Credit Amount	Funds Withheld	Protection Percentage	Exempt Capitations
1	Denise Sampson	125,000	5,000	0	4%	62,500
2	James Jones	50,000	5,000	0	10%	50,000
3	Dr. Dunleavy	750,000	5,000	50,000	7%	687,500
4	Dr. Clements	25,000	0	0	0%	0
5	All others	2,500,000				0
1999999	Total to Providers	3,450,000	xxx	xxx	xxx	800,000

(Figure 11)

Capitations Paid to Non-regulated Intermediaries

		(A)	(B)	(C)	(D)	(E)
					=(B+C)/A	=A*Min(1,D/16%)
Number	Name of Provider	Paid Capitations During Year	Letter of Credit Amount	Funds Withheld	Protection Percentage	Exempt Capitations
1	Mercy Hospital	2,500,000	200,000	300,000	20%	2,500,000
2	General	1,000,000	100,000	0	10%	625.000
3	Physicians Clinic	4,500,000	0	500,000	11%	3,125,000
4	Joe's HMO	3,500,000	0	0	0%	0
5	All others	2,500,000				0
2999999	Total to Unregulated Intermediaries	14,000,000	xxx	xxx	xxx	6,250,000

(Figure 12)

Capitations Paid to Regulated Intermediaries

Paid Capitations

Number	Name of Provider	During Year	Domiciliary State			Exempt Capitations
1	Fred's HMO	2,500,000	NY			2,500,000
2	Blue Cross of Guam	50,000	GU			50,000
3999999	Total to Regulated Intermediaries	2,550,000	xxx	xxx	xxx	2,550,000
9999999	Total of Figures (10), (11) and (12)	20,000,000	xxx	xxx	xxx	9,600,000

Divide the “Protection Percentage” by 8 percent (providers) or by 16 percent (unregulated intermediaries) to obtain the percentage of the capitation payments that are exempt. If the protection percentage is greater than 100 percent, the entire capitation payment amount is exempt. All capitations to regulated intermediaries qualify for the exemption.

The “Exempt Capitation” amount from Line 1999999 of $800,000 would be reported on Line (2) “Less Secured Capitations to Providers” in LR024 Health Credit Risk. The total of the “Exempt Capitation” amount from Line 2999999 plus Line 3999999 ($6,250,000+$2,550,000=$8,800,000) would be reported on Line (5) “Less Secured Capitations to Intermediaries” in LR024 Health Credit Risk.

BUSINESS RISK

LR025

Basis of Factors

General business risk is based on premium income, annuity considerations, and separate account liabilities. The formula factors were based on considering a company’s exposure to guaranty fund assessments without attempting to exactly mirror the assessment formulas. Also considered were other general business risk exposures, e.g., litigation, etc.

For life and annuity business, the RBC pre-tax contribution is 3.08 percent of Schedule T life premiums and annuity considerations before taxes.

A smaller pre-tax factor of 0.77 percent is applied against Schedule T accident and health premiums. The smaller factor for accident and health business recognizes that general business risk exposure is, in part, a function of reserves. Since life and annuity business typically carries higher reserves than accident and health business, a lower factor is used to achieve the same relative risk coverage as for life and annuity business.

To maintain general consistency with the Health RBC formula, an amount is determined as risk related to the potential that actual expenses of administering certain types of health insurance will exceed the portion of the premium allocated to cover these expenses. Not all administrative expenses are included (commissions, premium taxes and other expenses defined and paid as a percentage of premium are not included and the expenses for administrative services contracts (ASC) and administrative service only (ASO) business have separate lower factors) and the factor is graded based on a two tier formula related to health insurance premium to which this risk is applied. ASC is considered to have a separate business risk related to the use of the company’s funds with an expectation of later recovery of all amounts from the contractholder. Lines (51) and (52) apply a small factor to amounts reported as incurred claims for ASC contracts and separately for other medical costs. This separation allows for the cross-checking of incurred claims between Schedule H and the RBC filing.

Deposit-type funds shown on Schedule T are not included in the risk-based capital calculation.

For separate account business, a pre-tax factor of 0.08 percent is applied to separate account liabilities. Separate account business is generally not subject to guaranty fund assessments. As a result, most of the exposure in the separate account is reserve based. A lower factor is used here and applied to a higher number, i.e., reserves versus the use of premiums above, to achieve an appropriate level of risk coverage for a company's exposure to the general business risk in the separate account.

Since the RBC calculation is applied to separate account liabilities, Variable and Other Premiums and Considerations are excluded from the pre-tax 3.08 percent or 0.77 percent factors above. Variable and Other Premiums and Considerations are those on all variable business life, annuity and health (both fixed and variable components), as well as, on other business ultimately reserved for in the separate account. For 1999 these summations will be based on company records. For future years, annual statements will include this information.

Specific Instructions for Application of the Formula

Amounts reported for Business Risk should equal the Annual Statement references indicated. No adjustments are to be made.

Other Underwriting Risk - L(19) through L(41~~33~~) - XR013 – XR014 *(click here to return to attachment list)*

In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when reporting entities guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e. Comprehensive Medical, Medicare Supplement, Dental, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the federal employees health benefit program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by 2 percent to determine total underwriting RBC on this business.

A separate risk factor, consistent with the factor used in the Life RBC formula, is applied to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical. It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage and this product exhibits much higher variability, so a higher RBC factor of 25 percent is applied.

Lines (23) through (29~~8~~) Disability Income~~ and Long-Term Care~~. Disability Income ~~and Long-Term Care Insurance (LTCI)~~ Premiums are to be separately entered depending upon category (Individual and Group). For Individual Disability Income, a further split is between noncancellable (NC) or other (guaranteed renewable, etc.). For Group Disability Income, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). ~~LTCI premiums are reported separately for Individual noncancellable, Individual (other than NC) and Group LTCI.~~ The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. In determining the premiums subject to the higher factors, Individual Disability Income NC and Other is combined**.** All types of Group and Credit *Disability Income* are combined in a different category from Individual. ~~For long-term care, all types (Individual and Group) are combined.~~

Lines (30) through (37) Long Term Care. Long Term Care Insurance (LTCI) Premiums are used to determine both a rate risk and the morbidity risk. The rate risk relates to Noncancellable LTCI premiums and applies only to the first $50,000,000 of these premiums. The morbidity risk is partially applied directly to premium with a higher factor (25%) applied to amounts up to $50,000,000 and a lower factor (15%) applied to premiums in excess of $50,000,000. In addition, the earned premiums and incurred claims for the last three years are used to determine an average loss ratio **[details to be spelled out]**. This average loss ratio times the current year's premium is called Adjusted LTCI Claims for RBC. A higher factor (37%) is applied to claims up to $35,000,000 and a lower factor (12%) is applied to claims above $35,000,000. For 2005, the RBC amounts for morbidity risk are weighted **A%** for the premium component and **(1-A)%** for the claims component.

Line (38~~3~~) Limited Benefit Plans. There is a factor for certain types of Limited Benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5 percent) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (39~~4~~) Accidental Death and Dismemberment. There is a factor for Accidental Death and Dismemberment (AD&D) insurance (where a single lump sum is paid) which depends on several items:

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

4. 1.5 percent of earned premium in excess of $10,000,000.

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

Line (40~~35~~) Other Accident. There is a factor for Other Accident – coverage that provides for any accident-based contingency other than those contained in Line 30. For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

Line (41~~36~~) Premium Stabilization Reserves. Premium stabilization reserves are funds held by the company in order to stabilize the premium a group policyholder must pay from year to year. Usually experience-rating refunds are accumulated in such a reserve so that they can be drawn upon in the event of poor future experience. This reduces the insurers risk.

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

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

No credit is given here for premium stabilization reserves held for FEHBP and TRICARE coverage, because that coverage is already subject to a lesser percentage of premium in the underwriting risk calculation to reflect its reduced level of risk.

UNDERWRITING RISK - MANAGED CARE CREDIT – XR015

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

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

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

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

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

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

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

This amount should equal Exhibit **7**, Part 1, Column 1, Line 5 of the annual statement.

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

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

This amount should equal Exhibit **7**, Part 1, Column 1, Line 6 of the annual statement.

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

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

EXAMPLE - 2003 Reporting Year

2002 withhold / bonus payments 750,000
2002 withholds / bonuses available 1,000,000
A. MCC Factor Multiplier ....75% - Eligible for credit
2002 withholds / bonuses available................................. 1,000,000
2002 claims subject to withhold - **gross***..........................5,000,000
B. Average Withhold Rate..20%
Category 2 Managed Care Credit Factor (A x B).........................15%

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

*** These are amounts due before deducting withhold or paying bonuses**
**** These are actual payments made after deducting withhold or paying bonuses**

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses, but otherwise had no managed care arrangements. This amount should equal Exhibit **7**, Part 1, Column 1, Line 7 of the annual statement.

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

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

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit **7**, Part 1, Column 1, Line 8 of the annual statement.

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

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

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit **7**, Part 1, Column 1, Line 1 + Line 3 of the annual statement.

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

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

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

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

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

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

IN ORDER TO QUALIFY FOR ANY OF THE CAPITATION CATEGORIES, SUCH CAPITATION MUST BE FIXED (AS A PERCENTAGE OF PREMIUM OR FIXED DOLLAR AMOUNT PER MEMBER) FOR A PERIOD OF AT LEAST 12 MONTHS. Where an arrangement contains a provision for prospective revision within a 12 month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 1 for a provider, and for an intermediary at the greater of category 1 or a credit calculated using the underlying payment method(s) to the providers of care. Where an arrangement contains a provision for retroactive revisions either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit that is calculated under category 0 for both providers and intermediaries.

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

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

Salaries paid to doctors and nurses whose sole corporate purpose is utilization review are also included in this category if such payments are classified as "medical expense" payments (paid claims) rather than administrative

expenses. The "Aggregate Cost" method of reimbursement means where a health plan has a reimbursement plan with a corporate entity that directly provides care, where (1) the health plan is contractually required to pay the total operating costs of the corporate entity, less any income to the entity from other users of services, and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, which put their respective capital and surplus at risk in guaranteeing each other.

This amount should equal Exhibit **7**, Part 1, Column 1, Line 9 + Line 10 of the annual statement.

Line (9) - Total Paid Claims. The total of Column 2 paid claims should equal the total claims paid for the year as reported in Exhibit **7**, Part 1, Column 1, Line 13 less Line 11 of the annual statement less line (8.3).

Line (10) - Weighted Average Managed Care Discount. This amount is calculated by dividing the total weighted claims (Column 3) by the total claim payments (Column 2).

Line (11) - Weighted Average Managed Care Risk Adjustment Factor. This is the credit factor that is carried back to the underwriting risk calculation. It is one minus the Weighted Average Managed Care Discount (line 10).

Lines (12) through (18) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (12) - Enter the prior year's actual withhold and bonus payments.

Line (13) - Enter the prior year's withholds and bonuses that were available for payment in the prior year.

Line (14) - Divides Line (12) by Line (13) to determine the portion of withholds and bonuses that were actually returned in the prior year.

Line (15) - Equal to Line (13) and is automatically pulled forward.

Line (16) - Claim payments that were subject to withholds and bonuses in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (17) - Divides Line (15) by Line (16) to determine the average withhold rate for the prior year.

Line (18) - Multiplies Line (14) by Line (17) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the MCO's withhold/bonus program in the prior year.

CREDIT RISK XR017

Reinsurance Ceded - L(1) through L(17)

There is a credit risk associated with recoverability of amounts due from reinsurers. However, reinsurance with wholly owned subsidiaries is exempt from RBC requirements because affiliate risk is addressed elsewhere in the Health RBC formula. The RBC requirement is .5 percent of the annual statement value of recoverables, unearned premiums, and other reserve credits.

The annual statement references for reinsurance recoverables (paid and unpaid) come from Schedule S, Part 2. The annual statement references for unearned premiums and other reserve credits are in Schedule S, Part 3.

Capitations - L(18) through L(24)

Credit risk arises from capitations paid directly to providers or to intermediaries. The risk is that the MCO will pay the capitation but will not receive the agreed-upon services and will encounter unexpected expenses in arranging for alternative coverage. The credit risk RBC requirement for capitations paid directly to providers is 2 percent of the amount of capitations reported as paid claims in the Managed Care Credit Calculation page. This amount is roughly equal to two weeks of paid capitations.

However, a MCO can also make arrangements with its providers that mitigate the credit risk, such as obtaining acceptable letters of credit or withholding funds. Where the MCO obtains these protections for a specific provider, the amount of capitations paid to that provider are exempted from the credit risk charge. A separate Capitations worksheet is provided to calculate this exemption, but a MCO is not obligated to complete the worksheet.

The credit risk RBC requirement for capitations to intermediaries is 4 percent of the annual statement amount of the capitated payments reported as paid claims in the Managed Care Credit Calculation page. However, as with capitations paid directly to providers, the regulated MCO can eliminate some or all of the credit risk that arises from capitations to intermediaries by obtaining acceptable letters of credit or withheld funds.

Line (18) - Total Capitations Paid Directly to Providers. This is the amount reported in the Managed Care Credit Calculation page, L(5).

Line (19) - Less Secured Capitations to Providers. Computed from the Capitations worksheet, this includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 8% of annual claims paid to the provider. If lesser protection is provided (e.g., an acceptable letter of credit equal to 2% of annual claims paid to that provider), then the amount of capitation is prorated. The exemption is calculated separately for each provider and intermediary. A sample worksheet to calculate the exemption is shown on the next page of these instructions.

Line (20) - Capitations to Providers Subject to Credit Risk Charge. Line (18) minus Line (19).

Line (21) - Total Capitations to Intermediaries. From Line (6) and Line (7) of the Managed Care Credit Calculation page, this includes all capitation payments to intermediaries.

Line (22) - Less Secured Capitations to Intermediaries. Computed from the Capitations worksheet, this includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 16% of annual claims paid to the provider. If lesser protection is provided (e.g., an acceptable letter of credit equal to 5% of annual claims paid to that provider), then the amount of capitation is prorated. The exemption is calculated separately for each provider and intermediary. A sample worksheet to calculate the exemption is shown on the next page of these instructions.

CAPITATIONS TO PROVIDERS AND INTERMEDIARIES
CREDIT RISK EXEMPTION WORKSHEET

CAPITATIONS PAID DIRECTLY TO PROVIDERS

		A	B	C	D=(B+C)/A	E=A*Min(1,D/8%)
Number	Name of Provider	Paid Capitations During Year	Letter of Credit Amount	Funds Withheld	Protection Percentage	Exempt Capitations
1	Sally Smith	125,000	5,000	0	4%	62,500
2	Jim Jones	50,000	5,000	0	10%	50,000
3	Dr. Doolittle	750,000	5,000	50,000	7%	687,500
4	Dr. Clements	25,000	0	0	0%	0
5	All others	2,500,000				0
19999	Total to Providers	3,450,000	xxx	Xxx	xxx	800,000

CAPITATIONS PAID TO UNREGULATED INTERMEDIARIES

		A	B	C	D=(B+C)/A	E=A*Min(1,D/16%)
Number	Name of Provider	Paid Capitations During Year	Letter of Credit Amount	Funds Withheld	Protection Percentage	Exempt Capitations
1	Mercy Hospital	2,500,000	200,000	300,000	20%	2,500,000
2	Chicago Hope	1,000,000	100,000	0	10%	625.000
3	Bill's Clinic	4,500,000	0	500,000	11%	3,125,000
4	Joe's HMO	3,500,000	0	0	0%	0
5	All others	2,500,000				0
29999	Total to Unregulated Intermed	14,000,000	xxx	Xxx	xxx	6,250,000

CAPITATIONS PAID TO REGULATED INTERMEDIARIES

Number	Name of Provider	Paid Capitations During Year	Domiciliary State			Exempt Capitations
1	Fred's HMO	2,500,000	NY			2,500,000
2	Blue Cross of Guam	50,000	GU			50,000
39999	Total to Regulated Intermed	2,550,000	xxx	Xxx	xxx	2,550,000
99999	Total	20,000,000	xxx	Xxx	xxx	9,600,000

Divide the “Protection Percentage” by 8% (providers) or by 16% (unregulated intermediaries) to obtain the percentage of the capitation payments that are exempt. If the protection percentage is greater than 100%, the entire capitation payment amount is exempt. All capitations to regulated intermediaries qualify for the exemption.

The “Exempt Capitation” amount from Line 19999 of $800,000 would be reported on *L(19) Less Secured Capitations to Providers* in the Credit Risk page. The total of the “Exempt Capitation” amount from Line 29999 plus Line 39999 ($6,250,000+$2,550,000=$8,800,000) would be reported on *L(22) Less Secured Capitations to Intermediaries* in the Credit Risk page.

Line (23) - Capitations to Intermediaries Subject to Credit Risk Charge. L(21) – L(22).

Line (24) - Capitation Credit Risk RBC. Sum of L(20) and L(23).

Other Receivables - L(25) through L(30)

There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount of health care receivables, amounts due from parents, subsidiaries, and affiliates, and Aggregate write-ins for other than invested assets. Enter the appropriate value in Lines (25) through (29).

Line 26.1. Pharmaceutical rebates are arrangements between pharmaceutical companies and reporting entities in which the reporting entities receive rebates based upon the drug utilization of its subscribers at participating pharmacies. These rebates are sometimes recorded as receivables by reporting entities using estimates based upon historical trends which should be adjusted to reflect significant variables involved in the calculation, such as number of prescriptions written/filled, type of drugs prescribed, use of generic vs. brand-name drugs, etc. In other cases, the reporting entity determines the amount of the rebate due based on the actual use of various prescription drugs during the accumulation period and then bills the pharmaceutical company. Oftentimes, a pharmacy benefits management company may determine the amount of the rebate based on a listing (of prescription drugs filled) prepared for the reporting entity's review. The reporting entity will confirm the listing and the pharmaceutical rebate receivable. Pharmaceutical rebates may relate to insured plans or uninsured plans. Only the receivable amount related to the insured plans should be reported on this line. Amount comes from Exhibit 3, Column 7, Line 0199999**.**

Line 26.2. Claim overpayments may occur as a result of several events, including but not limited to claim payments made in error to a provider. Reporting entities often establish receivables for claim overpayments. Amount comes from Exhibit 3, Column 7, Line 0299999**.**

Line 26.3. A health entity may make loans or advances to large hospitals or other providers. Such loans or advances are supported by legally enforceable contracts and are generally entered into at the request of the provider. In many cases, loans or advances are paid monthly and are intended to represent one month of fee-for-service claims activity with the respective provider. Amount comes from Exhibit 3, Column 7, Line 0399999.

Line 26.4. A capitation arrangement is a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. In some instances, advances are made to a provider under a capitation arrangement in anticipation of future services. Amount comes from Exhibit 3, Column 7, Line 0499999**.**

Line 26.5. Risk sharing agreements are contracts between reporting entities and providers with a risk sharing element based upon utilization. The compensation payments for risk sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Amount comes from Exhibit 3, Column 7, Line 0599999.

Line 26.6 Any other health care receivable not reported in lines 26.1 through 26.5. Amount comes from Exhibit 3, Column 7, Line 0699999

Line 27. Only include on this line amounts receivable related to pharmaceutical rebates on uninsured plans that are in excess of the liability estimated by the reporting entity for the portion of such rebates due to the uninsured accident and health plans.

BUSINESS RISK – XR019

There are four major subcategories found in the Business Risk section of the formula: Administrative Expense Risk, Non-Underwritten and Limited Risk Business, Guaranty Fund Assessment Risk, and Excessive Growth Risk.

Administrative Expense Risk - L(1) through L(7) and L(20) through L(26)

There is a risk associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses. Estimates of administrative expense ratios are built into the price of providing medical care to subscribers, just as claims expenses are built into the rates. Like claim expenses, administrative expenses are subject to misestimation and therefore generate an RBC requirement, but lower than the RBC requirement for claim fluctuations.

Administrative Expense Risk encompasses both Claims Adjustment Expenses and General Administrative Expenses as separate items that should be reported on Lines 1 and 2, respectively.

The ASC and ASO revenues and expenses that are included in the Administrative Expenses reported in lines 1 and 2 should be removed from those lines by reporting the net amount of expenses to the revenues on lines 3 and 4. If the revenues are greater than the expenses for the ASC or ASO business then a negative amount will be reported on these lines in order to add back the net income from the ASC or ASO business. Keep in mind that only the ASC and ASO revenues and expenses that are included in the administrative expenses will be reported on lines 3 and 4.

ASC/ASO commissions that are reported within the Underwriting and Investment Exhibit, Part 3 of the annual Statement should be included in line 5.

Lines 20 through 26 calculate the RBC risk factor for administrative expense risk as a weighted average, using underwriting risk revenue as the weight. The factor is 7 percent of the first $25 million of underwriting risk revenue plus 4 percent of the underwriting risk revenues in excess of $25 million, divided by total underwriting risk revenues. The weighted average factor is then multiplied by the administrative expenses excluding administrative expenses associated with ASC/ASO business, premium taxes and commission payments. The ending charge is then prorated for administrative expenses related only to the managed care lines of business.

Non-Underwritten and Limited Risk - L(8) through L(11)

The risks associated with administrative services only (ASO) arrangements and administrative services contracts (ASC) are different than the risks of underwritten business. Therefore, the administrative expenses for these contracts are netted out of the total administrative risk category before applying a risk factor. However, there is still some risk that the administrative expenses for these contracts are insufficient to absorb the full outlay required and for the recovery of ASC claims payments. While the risk associated with these expenses is lower than that of general operating expense risk, it is still greater than zero.

ASO administrative fees, and reimbursements under ASC contracts for both administrative fees and the medical costs paid (ASC only), are included in the Non-Underwritten and Limited Risk Base. Note: the claim payments under ASC contracts SHOULD NOT be included in the Underwriting Risk section; they are reported in the Non-Underwritten and Limited Risk section only.

The RBC requirement for administrative expenses on non-underwritten and limited risk business is 2 percent of both ASC administrative expense and ASO administrative expenses. The RBC requirement for claims payments paid though ASC arrangements is 1 percent of the medical expense payments.

The RBC requirement for fee-for service revenues received from other reporting entities is also 1 percent.

Guaranty Fund Assessment Risk - L(12)

If the reporting entity is subject to guaranty fund assessments in any state, there is an RBC requirement of .5 percent of the direct earned premiums subject to assessment in that state. Premiums subject to guaranty fund assessments that are reported in Schedule T should be aggregated and reported in Line (12).

Excessive Growth Risk - L(13) through L(19)

Excessive growth risk is an important element of the Health RBC formula. Several recommendations for recognizing growth risk were considered, including growth in underwriting risk RBC by line of business, growth in premium, and growth in enrollment. However, these various measurements did not discriminate between reporting entities that had controlled growth with no accompanying increase in underwriting risk and those that were growing in both volume and risk. Additionally, the working group wanted to avoid imposing a growth charge that would unfairly discriminate against start-up companies where high growth rates were the norm.

The risk charge for excessive growth is set as a function of both growth in underwriting risk revenue and in underwriting risk RBC. A "safe harbor" level of growth is established as the growth rate in premiums plus 10 percent. Therefore, if the reporting entity had an increase in underwriting risk revenue volume of 30 percent, its underwriting risk RBC could grow up to 40 percent before any additional growth risk RBC is generated. That way, an entity that doubles its volume without more than doubling its RBC will not be subject to the excessive growth RBC charge. However, an entity that doubles its' RBC without doubling its underwriting risk revenue volume can be expected to trigger the excessive growth charge.

To calculate excessive growth risk RBC in future years, enter prior year's underwriting risk revenue [Prior Year Underwriting Risk – Experience Fluctuation Risk page, Column (6), Line (5)] in Line (13). The current year's underwriting risk revenue is automatically imported to Line (14) from this year's table. The prior year's Net Underwriting Risk RBC [Prior Year Underwriting Risk – Experience Fluctuation Risk page, C(6), L(18)] is entered on Line (15) and the current year value is pulled automatically into Line (16). The growth rate in underwriting risk revenue plus 10 percent is multiplied times the prior year's Net Underwriting Risk RBC in Line (15) to establish the safe harbor level for the current year.

If there has been a merger or divestiture during the period, the values must be restated to reflect either the combination or division as if it had been in place at the beginning of the period. For example, if a merger takes place during 2001, the end-of-year-2000 underwriting risk revenue and the end-of-year-2000 net underwriting risk RBC must both be adjusted to include the merged entity as if it had been owned in the prior year.

As long as the current year's Net Underwriting Risk RBC in Line (16) is lower than the safe harbor amount in Line (17), there is no excessive growth risk charge. If the current year's Net Underwriting Risk RBC is greater than the safe harbor amount, then the excess over the safe harbor value appears in Line (18). The excessive growth risk charge in Line (19) is one half of the value in Line (18).