

UNDERWRITING RISK – XR011

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

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

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula therefore requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. [Appendix 1 contains commonly used terms for general types of health insurance.](#) [Appendix 2 contains terms specifically used with respect to Medicare Part D coverage of prescription drugs.](#)

Claims Experience Fluctuation

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

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

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to ~~twice~~ a multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at \$750,000 per individual and \$1,500,000 total for medical coverage; ~~\$375,000 for non-hospital (inpatient charges and outpatient facilities charges) provider services-only business; and~~ \$25,000 per individual and \$50,000 total for all other coverage except Medicare Part D coverage and \$25,000 per individual and \$150,000 total for Medicare Part D coverage. Additionally, for multiline organizations (e.g., writing ~~both medical and dental~~ more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of \$~~1,500,000~~ \$750,000) and dental (with a cap of \$~~250,000~~ \$50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

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

L(1) through L(18)

There are ~~four~~ five lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital, (2) Medicare Supplement, (3) Dental (4) Medicare Part D coverage and (45) Other. Each of these lines

of business has its own column in the Underwriting Risk - Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

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), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 21 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000. Prescription drug benefits included in major medical insurance plans ([including Medicare Advantage plans with prescription drug coverage](#)) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement [and includes Medicare Select](#). Medicare risk business is reported under comprehensive medical and hospital.

Dental. This is limited to ~~these are premiums for~~ policies providing for dental 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.

Medicare Part D Coverage. [This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See Appendix 2 for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D \(benefits in excess of the standard benefit design\) are addressed separately in XR013. Employer-based Part D coverage that is in an uninsured plan as defined in SSAP No. 47 is not to be included here but is handled in Line 21 of this section.](#)

Other Health Coverages. Includes other coverages such as stand alone vision, [other](#) stand-alone prescription drug benefit plans [not included above](#), and coverages that have not been specifically addressed.

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

Line (1) Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Neither does it include federal employees health benefit programs (FEHBP). Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Line 1+ 2 of the annual statement. [For Medicare Part D Coverage the premium includes beneficiary premium \(standard coverage portion\), direct subsidy, low income subsidy \(premium portion\), Part D payment demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. It does not include revenue received for reinsurance payments or low income subsidy \(cost-sharing portion\) which are considered funds received for uninsured plans in accordance with EAIWG Int. No. . Beneficiary premium \(supplemental benefit portion\) is reported as separate premium in Line 22.x of XR013.](#)

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

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

This includes the beneficiary premium and federal government’s direct subsidy for prescription drug coverage under MA-PD plans. -The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Line 1 + 2 of the annual statement.

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

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

Line (5) Underwriting Risk Revenue. The sum of Lines (1) 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 reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) claims. These amounts are found Page 7, Line 17 of the annual statement.

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

Line (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 from non member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (8) 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
Medical Only	0.150	0.150	0.090
Medicare Supplement	0.105	0.067	0.067
Dental	0.120	0.076	0.076
Medicare Part D Coverage	0.xxx	0.yyy	0.yyy
Other	0.130	0.130	0.130

Line (11) Base Underwriting Risk RBC. Line (5) x Line (9) x Line (10).

Line (12) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental. ~~A~~ managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (11) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (11) of the Managed Care Credit Calculation page.

There is no discount given for ~~the e~~Other lines of business.

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

Line (14) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than \$750,000 per member ~~(\$375,000 for reporting entities providing only “professional component” coverage and \$25,000 for all other lines)~~, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and \$750,000.
- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity’s participation in the stop-loss layer (up to \$750,000 less retention).

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

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

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

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

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

Line (15) Alternate Risk Charge. This is twice the amount in Line (14) for all columns except column (4) and six times the amount in Line (14) for column (4), subject to a maximum of \$1,500,000 for ~~comprehensive medical~~column (1), ~~and~~-\$50,000 for ~~the other lines~~columns (2), (3) and (5) and \$150,000 for column (4).

Line (16) Alternate Risk Adjustment. This line shows the largest value in Line (15) for the column and all columns left of the column. ~~adjusts for the cumulative amounts of alternative risk charges that appear in Line (15). The calculation is the minimum of either the amount in Line (15) or the sum of Line (17) in each of the preceding columns, starting with Line (16); Column (1) equal to zero.~~

Line (17) Net Alternate Risk Charge. This is the amount in ~~up to twice the maximum retained risk on any individual from~~ Line (15) ~~less, adjusted by the cumulative amounts in the previous column of~~ Line (16) but not less than zero.

Line (18) Net Underwriting Risk RBC. This is the maximum of Line (13) and Line (17) for each of columns (1) through (5). The amount in column (6) is the sum of the values in columns (1) through (5).

Other Underwriting Risk - L(19) through L(42) - XR013 – XR015

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, Medicare Part D Coverage, Supplemental benefits within Medicare Part D Coverage, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

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

Line (22.x) Supplemental benefits within Medicare Part D coverage. A separate risk factor has been established to recognize the different risk (as described in Appendix 3) for the additional premium collected from beneficiaries for these supplemental drug benefits.

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

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

Line (39) 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 (40) 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 (41) 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 (42) 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. Amounts held as prepayments from the federal government for reinsurance coverage or low income subsidy (cost-sharing portion) under Medicare Part D Coverage are not considered premium stabilization reserves as they relate to an uninsured plan.

UNDERWRITING RISK - MANAGED CARE CREDIT – XR016

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, other than for Medicare Part D Coverage, 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

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, new Lines (x.1) through (x.4) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

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) - Sub-Total Paid Claims. The total of ~~Column 2~~ paid claims [for Comprehensive Medical, Medicare Supplement and Dental.](#) [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 (x.1)

Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (x.2)

Category 1 for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (x.3)

Category 2a for Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (x.4)

Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (x.5) - Sub-Total Paid Claims – The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

Line (10) - Weighted Average Managed Care Discount. ~~These~~~~is~~ amounts ~~are~~~~is~~ calculated by dividing the total weighted claims ~~(Column 3)~~ by the comparable sub-total claim payments ~~(Column 2)~~. For Column (3), this is Column (3) Line (9) divided by Column (2) Line (9). For Column (4), this is Column (4) Line (x.5) divided by Column (2) Line (x.5).

Line (11) - Weighted Average Managed Care Risk Adjustment Factor. ~~These~~~~is~~ ~~are~~~~is~~ the credit factors that ~~are~~~~is~~ carried back to the underwriting risk calculation. ~~It is~~They are one minus the Weighted Average Managed Care Discount values in (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. These do not apply to Medicare Part D coverage.

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 XR018

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. [There is no credit risk for any portion of the managed care discount factor for Medicare Part D Coverage.](#)

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/1 6%)
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 – XR020

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 through ASC arrangements is 1 percent of the medical expense payments ([not including Medicare Part D payments under the reinsurance payment or low income subsidy \(cost sharing portion\)](#)).

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. [For 2006, these calculations will exclude the premiums and Net Underwriting Risk RBC applicable to Medicare Part D coverage as this line of business did not exist prior to January 1, 2006.](#)

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).

APPENDIX 1 - COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicated from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

Administrative Expenses - Costs associated with the overall management and operations of the reporting entity that are not directly related to, or in direct support of providing medical services. Expenses to administer ASC, ASO business, and related revenue must be identified separately from underwritten business. Commission payments and premium taxes are excluded for RBC calculation purposes

Administrative Services Contract (ASC) - A contract where the reporting entity agrees to provide administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. The administrator may arrange for provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self insured) bears all of the insurance risk, and there is not possibility of loss or liability to the administrator caused by claims incurred related to the plan. Claims are paid from the reporting entity's own bank accounts, and only subsequently receives reimbursement from the uninsured plan sponsor. No arrangement where the reporting entity receives a capitated payment for providing medical services to a third party shall qualify as an insured plan.

ASC Reimbursements - Funds received by the reporting entity under an ASC contract as reimbursement for claims payments and for expenses associated with administering the contract.

Administrative Services Only (ASO) - A contract where the reporting entity agrees to provide administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. The administrator may arrange for provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self insured) bears all of the insurance risk, and there is not possibility of loss or liability to the administrator caused by claims incurred related to the plan. Claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, but only after the reporting entity has received funds from the uninsured plan sponsor that are adequate to fully cover the claim payments. No arrangement where the reporting entity receives a capitated payment for providing medical services to a third party shall qualify as an insured plan.

ASO Reimbursements - Funds received by the reporting entity under an ASO contract as a fee for expenses associated with administering the contract.

Admitted Assets - Assets recognized and accepted by a State Commissioner or Superintendent in determining the solvency of the reporting entity.

Affiliate - a person or entity that directly, or indirectly through one or more other persons or entities, controls, is controlled by, or is under common control with the reporting entity.

Aggregate Cost Payments - 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.

Claims - Payments made for medical services arranged for or provided by the MCO to its members, including payments for direct support of medical services arranged or provided by the MCO, less fee-for-service revenue directly related to such payments. Payments for services rendered to non-members of an MCO are excluded from claims, and associated fee for service revenue may not be deducted from claims, except in cases where non-contingent salaries are paid to employee providers regardless of whether they provide care to members or non-members of the MCO.

Health Care Delivery Assets - Land, buildings, equipment and supplies used directly to deliver health care to members as defined by SSAP 73.

Health Care Receivable - Fee-for-service, coordination of benefits and subrogation, co-payments, and other health balances. For RBC purposes, exclude ASC reimbursements due and reinsurance recoveries.

Hospital Indemnity Coverage - Coverage that provides a pre-determined, fixed benefit or daily indemnity for contingencies based on a stay on a hospital or intensive care facility.

Intermediary - 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 a reporting entity and its enrollees via a separate contract between the intermediary and the reporting entity.

Managed Care Organization (MCO) - Any person, corporation or other entity which enters into arrangements or agreements with licensed medical providers or intermediaries for the purpose of providing or offering to provide a plan of health benefits directly to individuals or employer groups in consideration for an advance periodic charge (premium) per member covered.

Maximum Retained Risk - The maximum level of potential claim exposure (capped at \$750,000 for medical coverage and \$25,000 for all other coverage) resulting from coverage on a single member of a reporting entity. Maximum retained risk for reporting entities providing “professional component” (non-hospital) coverage will be capped at \$375,000. Where specific stop-loss reinsurance protection is in place, this is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than \$750,000 per member (\$375,000 for reporting entities providing “professional component” coverage only), the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and \$750,000

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

Non-Admitted Assets - Assets that are not accepted by a State Commissioner or Superintendent in determining the solvency of the reporting entity.

Non-contingent salaries - Salaries paid to providers of medical care which cannot be adjusted based upon utilization of services (e.g. # of patients seen or the intensity of the illnesses treated)

Premiums - This is the amount of money charged by the reporting entity for the specified benefit plan. It is the prepaid (usually on a per member per month basis) payments made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization.

Professional Services - Health care services provided by a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

Provider Stop-loss - Coverage afforded to a provider via the risk sharing mechanisms within the reporting entity’s contract with such provider in exchange for a reduced payment to the provider. Also includes insurance (not reinsurance) purchased by the provider (or an intermediary) directly from a licensed insurer.

Regulated Intermediary - A *Regulated Intermediary* is an intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state. (See also Intermediary)

Reinsurance - An agreement between a reporting entity and a licensed (re)insurer whereby the reinsurer agrees, in exchange for a premium, to indemnify the reporting entity on a proportional or non-proportional basis, against a specified part of the cost of providing a plan of health benefits to its enrolled groups and individuals.

Risk Revenue - Amounts charged by the reporting entity as a provider or intermediary for specified medical services provided to the policyholders or members of another insurer or 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 reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation at the same factor as premiums and are subject to the same managed care credit categories. *NOTE: RISK REVENUE IS VERY SIMILAR TO REINSURANCE ASSUMED.*

Specified Disease Coverage - Coverage that provides primarily pre-determined benefits for expenses for the care of cancer and/or other specified diseases.

Stop Loss Coverage - Coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product. Coverage may apply on a specific basis, an aggregate basis or both. Specific coverage means that the stop loss carrier's risk begins after a minimum of at least \$5,000 of claims for any one covered Life has been covered by the group plan, provider/provider group or direct writer. Aggregate coverage means that the stop loss carrier's risk begins after the group plan, provider/provider group or direct writer has retained at least 90% of expected claims, or the economic equivalent.

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APPENDIX 2 – COMMONLY USED TERMS FOR MEDICARE PART D COVERAGE

The federal Centers for Medicare and Medicaid Services (CMS) oversees the Medicare Part D prescription drug coverage, including both coverage provided through a stand-alone Prescription Drug Plan (PDP) and coverage provided as part of a Medicare Advantage plan. CMS ascribes a specific meaning to most of the following terms, and the RBC formulas have adopted that terminology to reduce the potential for misinterpretation. Other terms have been defined below in order to facilitate the appropriate application of the RBC formula.

Beneficiary Premium (Standard Coverage Portion) – The amount received from the Part D enrollee (directly, or from CMS after being withheld from Social Security benefits) as payment for the Standard Coverage. This includes any late enrollment penalties that the PDP Sponsor receives for an enrollee. The Beneficiary Premium is accounted for as health premium.

Beneficiary Premium (Supplemental Benefit Portion) – The amount received from the Part D enrollee (directly, or from CMS after being withheld from Social Security benefits) as payment for Supplemental Benefits. The Beneficiary Premium is accounted for as health premium.

Coverage Year Reconciliation – A reconciliation made after the close of each calendar year, to determine the amounts that a PDP Sponsor is entitled to for the Low-Income Subsidy (Cost-Sharing Portion), the Reinsurance Payment, and the Risk Corridor Payment Adjustment. To the extent that interim payments (if any) from CMS exceeded the amounts determined by the reconciliation, the PDP Sponsor must return the excess to the government; to the extent that interim payments (if any) from CMS fell short of the amounts determined by the reconciliation, the government will make an additional payment to the PDP Sponsor. The Coverage Year Reconciliation results in the Low-Income Subsidy (Cost-Sharing Portion) and the Reinsurance Payment being essentially a self-insured (by the government) component of the Part D coverage, subject to SSAP No. 47. The Coverage Year Reconciliation also results in the treatment of the Risk Corridor Payment Adjustment as a retrospective premium adjustment, subject to SSAP No. 66.

Direct Subsidy – The amount the government pays to the PDP Sponsor for the Standard Coverage. These payments are accounted for as health premium.

Low-Income Subsidy (Cost-Sharing Portion) – The amount the government pays to the PDP Sponsor for additional benefits provided to low-income enrollees. The additional benefits may include payment for some or all of the deductible, the coinsurance, and the copayment above the out-of-pocket threshold. These payments are accounted for as payments made under a self-insured plan.

Low-Income Subsidy (Premium Portion) – The amount the government pays to the PDP Sponsor for low-income enrollees in lieu of part or all of the Beneficiary Premium (Standard Coverage Portion). These payments are accounted for as health premium.

Part D Payment Demonstration – A payment from the government to a PDP Sponsor participating in CMS’s Part D Payment Demonstration. The Payment Demonstration is a special arrangement in which the PDP sponsor receives a predetermined per-enrollee capitation payment and the government no longer provides reinsurance for the 80% of costs in excess of the out-of-pocket threshold. Rather, the PDP sponsor assumes the risk for this 80% of costs, in addition to its normal 15% share of costs in excess of this threshold. However, risk corridor protection does still apply to this 80% share of costs. These payments are accounted for as health premium.

PDP Sponsor – The entity that provides stand-alone Part D coverage (as opposed to Part D coverage provided through a Medicare Advantage plan).

Reinsurance Coverage – Medicare Part D coverage for which the PDP sponsor may receive additional amounts under the Reinsurance Payment. This does not include payments under the Part D Payment Demonstration.

Reinsurance Payment – An amount paid by the government for benefit costs above the out-of-pocket threshold (see “Standard Coverage”). Generally, when costs exceed the out-of-pocket threshold, the government pays 80% of the costs, the enrollee pays 5% (or specified copayments, if greater), and the PDP Sponsor pays the remainder (typically, 15% of the costs). The amount paid by the government is treated as a claim payment made by a self-insured benefit plan rather than as revenue to the PDP Sponsor, and the claims do not flow through the PDP sponsor’s income statement. In cases where the

government prepays the Reinsurance Payment on an estimated basis, the prepayment is treated as a deposit, which again does not pass through the PDP Sponsor's income statement.

Risk Corridor Payment Adjustment – An amount by which the government adjusts its payments to the PDP Sponsor, based on how actual benefit costs vary from the costs anticipated in the PDP Sponsor's bid for the Part D contract (the “target amount” of costs). The government establishes thresholds for symmetric risk corridors around the target amount, using percentages of the target amount. If actual costs exceed the target amount but are less than the first threshold upper limit, then no adjustment is made. If actual costs exceed the first threshold upper limit, the government will make an additional payment equal to 50% (75% in 2006 and 2007, or 90% under some circumstances) of the excess that falls between the first and second thresholds, and 80% of the excess that falls above the second threshold. However, if actual costs are less than the target amount, then the PDP Sponsor must make a comparable payment to the government. For 2006 and 2007, the first and second thresholds are 2.5% and 5%, respectively; for 2008-2011, they are 5% and 10%; and for 2012 and later, the thresholds have not yet been established, but will be no less than the 2008-2011 values. Risk corridor payment adjustments are accounted for as retrospective premium adjustments on retrospectively rated contracts.

Risk Corridor Protection – Medicare Part D coverage for which the PDP sponsor may receive (or pay) additional amounts under the Risk Corridor Payment Adjustment. Most employer plans providing Medicare Part D are not subject to Risk Corridor Payment Adjustments.

Standard Coverage – The Part D benefit design that conforms to certain standards prescribed by the government. The standard coverage comprises: no coverage for an annual initial deductible; coverage net of a coinsurance provision (25% of costs are payable by the insured) for costs up to an initial coverage limit; a range beyond the initial coverage limit, in which the insured pays all of the prescription drug costs –i.e. no coverage by the PDP; and an annual out-of-pocket threshold, above which the insured pays the greater of a specified copayment or 5% of the drug cost. The various limits and thresholds are set at specified dollar amounts for 2006, which will be increased in later years based on the growth in drug expenditures. Wherever the term “Standard Coverage” is used as part of these instructions, the same treatment would be applied to coverage that has been approved as actuarially equivalent coverage. With respect to amounts above the out-of-pocket threshold, see the definitions of “Reinsurance Payment” and “Reinsurance Payment Demonstration Capitation.”

Supplemental Benefits – Benefits in excess of the Standard Coverage. These benefits typically will cover some portion of the deductible, the copayments, or the “coverage gap” between the initial coverage limit and the out-of-pocket threshold. Supplemental Benefits are part of an enrollee's Part D coverage, so they are not placed in the “Other” category in the RBC formula. However, they are not subject to either the Reinsurance Payment or the Risk Corridor Payment Adjustment, so they receive less favorable RBC treatment than the Standard Coverage.