

HEALTH PREMIUMS and HEALTH CLAIM RESERVES

LR016, LR020 and LR021

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, or Medicare Part D coverage through a PDP arrangement, 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. Appendix 3 of these instructions lists commonly used terms specific to Medicare Part D coverage. If the company has any of the ~~three~~four 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 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.

Long Term Care Insurance Premium

Prior to 2005, factors equal to the original disability income ~~factors~~ were used. Starting in 2005, factors based on LTC experience replace those factors. The difference in the factors used in 2004 and prior years for Noncancellable LTC versus other LTC has been retained as a Rate Risk factor applied to the NC premium. 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 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 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.

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.

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, the pre-tax factors on pages 26-28 and in LR020 Long-Term Care will be adjusted to post-tax by applying a tax-effect change to RBC in LR027. 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 Workers 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.

Line (1)

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).

Line (2)

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).

Line (3)

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).

Line (X.1)

Health premium for Medicare Part D coverage written on individual contracts - 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 3 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (1). No RBC requirement is calculated in Column (2). The premium is carried forward to page **LR017** Underwriting Risk – Experience Fluctuation Risk Column (4) Line (1.1).

Line (X.2)

Health premium for Supplemental benefits within Medicare Part D coverage written on individual contracts that is beneficiary payment (supplemental benefit portion) – e.g. coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible. This does not include the low-income subsidy (cost sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Medicare Part D Coverage on **LR016**.

Line (4) and Line (11)

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 (5) and Line (12)

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.

Line (6) and Line (13)

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).

Line (Y.1)

Health premium for Medicare Part D coverage written on group contracts only if the plan sponsor has risk corridor protection for the contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor protection payments. See Appendix 3 for definition of these terms. Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (27). This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (7). No RBC requirement is calculated in Column (2). The premium is carried forward to page **LR017** Underwriting Risk – Experience Fluctuation Risk Column (4) Line (1.2).

Line (Y.2)

Health premium for Supplemental benefits within Medicare Part D coverage written on group contracts that is beneficiary payment (supplemental benefit portion) – e.g. coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible where the plan sponsor has risk corridor protection for the group contract's standard benefit design coverage. This does not include the low-income subsidy (cost-sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Part D Coverage on **LR016**.

Lines (15) through (21)

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). 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.

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.

| | <u>Annual Statement Source</u> | <u>(1) Statement Value</u> | <u>Factor</u> | <u>(2) RBC Requirement</u> |
|----------------------------------|--|--|---------------|--------------------------------|
| <u>Disability Income Premium</u> | | | | |
| <u>Line (15)</u> | 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 | | |
| b) | Over \$50 Million Earned Premium of Line (15) | Company Records | X 0.539 = | |
| c) | Total Noncancellable Disability Income - Individual Morbidity | a) of Line (15) + b) of Line (15), Column (2) | X 0.231 = | |
| <u>Line (16)</u> | 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) | | |
| <u>Line (17)</u> | 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) | | |
| <u>Line (18)</u> | 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) | _____ | _____ |
| <u>Line (19)</u> | 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) | _____ | _____ |
| <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) | _____ | _____ |

Lines (22) and (23)

Premiums for noncancelable long-term care insurance are included on line (22) to reflect the additional risk when rate increases are not permitted. Line (23) includes premiums for Other LTC coverage but with no RBC value on this page (the RBC is determined on LR020 Long-Term Care) so that the validation check to Schedule H can still be performed.

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.

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) of LR019 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.

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~~ 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 two times the maximum or \$1,500,000 for Comprehensive Medical; two times the maximum or \$50,000 for each of Medicare Supplement business and ~~\$50,000 for~~ dental coverage and six times the maximum or \$150,000 for Medicare Part D coverage.

Line (1) through Line (18)

There are ~~three~~four 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~~four lines of business are: Column (1) Comprehensive Medical and Hospital, Column (2) Medicare Supplement, ~~and~~ Column (3) Dental & Vision and Column (4) Medicare Part D coverage. ~~The other column of LR017 is not to be used.~~ Each of the ~~three~~four 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 includes Medicare Advantage, with or without prescription drug benefits. 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.

Medicare Part D Coverage

Includes policies and contracts providing the standard coverage for individuals enrolled in Medicare Part D and the insurance is a federally approved PDP with risk corridor protection. It does not include risk revenue for Supplemental benefits within Medicare Part D coverage that is a portion of the PDP's approved package. It does not include employer coverage unless the coverage meets the above criteria. Where there is a federal subsidy to the employer in lieu of risk corridor protection, the premiums are to be reported as "Other Health."

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.

For Medicare Part D Coverage, this will include only certain amounts paid by the individual, an employer or CMS. See Appendix 3 for details of what is and is not premium income.

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. This includes the premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans.

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. Revenue from Medicare Part D coverage under the low income subsidy (cost sharing portion) and low income subsidy (premium portion) are not included in this line.

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 LR026 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.

For Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined under the Reinsurance Payment in Appendix 3). 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 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 |
| Medicare Part D Coverage | 0.xxx | 0.yyy | 0.yyy |

Line (11) Base Underwriting Risk RBC

Line (5) x Line (9) x Line (10.3).

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 claims payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (11) of LR019 Underwriting Risk - Managed Care Credit. 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 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 ~~three~~ 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 ~~three~~ 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) |
| | <u>+\$50,000</u> (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) |
| | <u>+\$67,500</u> (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~~ Medicare Supplement and Dental. Six times the amount in Line (15), subject to a maximum of \$150,000 for Medicare Part D Coverage.

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, [Medicare Part D Coverage](#), 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. The RBC factors for the Workers' Compensation Carve-Out will be phased in over three years in even increments beginning in 2004 and concluding in 2006. A factor of 0.364 (0.243 for 2005) is applied against net premiums written as shown in the Workers Compensation Carve-Out Supplement. A factor of 0.347 (0.231 for 2005) 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 (0.040 for 2005) 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, [Medicare Part D Coverage](#) 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 [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, 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.

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 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 (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 (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~~ ~~ese are~~ ~~is~~ the credit factors that ~~is~~ ~~are~~ carried back to the underwriting risk calculation. ~~It is~~ They are 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.

LONG-TERM CARE

LR020

The Long Term Care Morbidity Risk is calculated in part based on the current year's earned premium. The premium is separated into the total not to exceed \$50,000,000 to which a larger factor is applied and amounts in excess of \$50,000,000 to which a lower factor is applied. This is done in lines (1) through (3) of LR020 Long-Term Care.

Another portion of the Morbidity Risk is applied to incurred claims. This is done in Lines (4.1) through (6). To reduce the volatility of claims, the current and prior year's results are averaged using loss ratios. This is done in lines (4.1) through (4.3). The average loss ratio is applied to current year's earned premium to get Adjusted LTC Claims for RBC in Line (5). To allow for those situations where either there is no positive earned premium or one of the loss ratios is negative, the RBC formula uses the actual incurred claims for the current year. The claims-based RBC is separated into amounts up to \$35,000,000 to which a higher factor is applied in line (5.1) and amounts in excess of \$35,000,000 in line (5.2). In addition, if Line 1, column 1 is not positive, a larger factor is applied to actual incurred claims (if positive) to reflect the fact that there is no premium-based RBC.

PREMIUM STABILIZATION RESERVES

LR023

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. 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.

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

LR025

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. There is no credit risk for any portion of the managed care discount factor for Medicare Part D Coverage.

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

| Number | Name of Provider | (A) | (B) | (C) | (D) | (E) |
|---------|--------------------|---------------------------------|----------------------------|----------------|--------------------------------------|---|
| | | Paid Capitations During Year | Letter of Credit Amount | Funds Withheld | =(B+C)/A Protection Percentage | =A*Min(1,D/8%) 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

| Number | Name of Provider | (A) | (B) | (C) | (D) | (E) |
|---------|-------------------------------------|------------------------------|-------------------------|----------------|-----------------------------------|---------------------------------------|
| | | Paid Capitations During Year | Letter of Credit Amount | Funds Withheld | =(B+C)/A Protection Percentage | =A*Min(1,D/16%) 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

| Number | Name of Provider | Paid Capitations | Domiciliary State | | Exempt Capitations |
|---------|--------------------------------------|------------------|-------------------|-----|--------------------|
| | | During Year | | | |
| 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 | 2,550,000 |
| 9999999 | Total of Figures (10), (11) and (12) | 20,000,000 | 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 LR025 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 LR025 Health Credit Risk.

BUSINESS RISK
LR026

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 but this does not include Medicare Part D coverage. 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.

Appendix 2 - Commonly Used Health Insurance Terms

The DEFINITIONS OF COMMONLY USED TERMS section are frequently duplicates 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 insurer 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 insurer 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.

ASC Reimbursements - Funds received by the company 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 insurer 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.

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

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.

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

Managed Care Organization (MCO) - Any person, corporation or other entity (other than an insurer) 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 an insurer. Maximum retained risk for companies 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 companies 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 insurer, the maximum retained risk as calculated above will be increased by the insurer’s participation in the stop-loss layer (up to \$750,000 less retention).

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 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 required to file the MCO RBC formula with the state. (See also Intermediary)

Risk Revenue - Amounts charged by the reporting insurer 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 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 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 in 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 percent of expected claims or the economic equivalent.

Appendix 3 – 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.