May 29, 1996

PS-96-H-15

The Honorable Commissioner Robert E. Wilcox Utah State Insurance Department State Office Building, Room 3110 Salt Lake City, UT 84114

Dear Commissioner Wilcox:

Enclosed is the Final Report to the National Association of Insurance Commissioners Health Organizations Risk-Based Capital Working Group. This report represents the work of the American Academy of Actuaries Health Organizations Risk-Based Capital Simplification Task Force.

With this report, we have completed the items outlined in our November 28, 1995 letter to you. Specifically, the report contains a simplified HORBC formula and the worksheets and instructions for its implementation. The report also includes information on the variety of health care delivery asset structures of HMOs the solvency issues they present, and the valuation and admission considerations of these assets.

Our changes to the HORBC formula are consistent with your simplification goals to maintain the formula's sensitivity to the risks recognized in the December 1994 HORBC formula and to accommodate the specificity, auditability, and availability of the inputs to the formula. Our primary criterion for the changes was to maintain sensitivity to the original formula, which is reflected in a formula that remains consistent with the original HORBC formula.

The package includes the report and a number of appendices. The report provides a summary of the Task Force's process, analyses, discussions, and simplification proposal. Appendix 4 is the written simplification of the HORBC formula. Appendix 5 and 6 are the worksheets and worksheet instructions that apply the simplified formula. Appendix 7 contains the annual statement proposed changes and instructions that support the inputs or input audits to the HORBC formula. The remainder of the appendices provide additional technical or historical detail.

This simplified HORBC formula proposal expands the sensitivity of RBC to health risks from the current Life and Health formula and reduces some sensitivity of RBC from the original HORBC formula. This implies that companies will find their health coverage RBC changing under the simplified formula depending upon their mix and size of health coverages in force. The NAIC should expect comments on the impact of the revised formula on specific companies and should test the formula on actual companies' risk composition.



The Honorable Commissioner Robert E. Wilcox May 29, 1996 Page Two

Finally, as the simplified formula is reviewed by a larger number of carriers, we expect that a number of clarifications and minor revisions will be required to the worksheets and instructions to make them execute the simplified formula. We are prepared to support this fine tuning of the worksheets and instructions.

As noted at the Spring NAIC meeting, we appreciate the support and guidance of your Working Group, NAIC staff, and the large number of professionals who participated in, and provided input and guidance to, the Task Force during its work.

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Sincerely,

C. Inka

Peter L. Perkins, F.S.A., M.A.A.A. Chairman, State Health Committee Chairman, Health Organizations Risk-Based Capital Simplification Task Force







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FINAL REPORT TO

THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

HEALTH ORGANIZATIONS RISK-BASED CAPITAL WORKING GROUP

HEALTH ORGANIZATIONS RISK-BASED CAPITAL SIMPLIFICATION TASK FORCE

JUNE 1996

:

The American Academy of Actuaries (Academy) is a national organization that was formed in 1965 to bring together, into a single entity, actuaries of all specialties in the United States. The Academy provides technical actuarial expertise to elected officials and maintains the actuarial profession's standards of qualification, practice, and conduct. The Academy offers expert testimony, provides technical information, comments on proposed legislation, and works closely with federal and state officials on insurance-related issues.

This report was prepared for the National Association of Insurance Commissioners at the request of Commissioner Robert Wilcox, Chairman of the Health Organizations Risk Based Capital Working Group. This report represents the collective work of the Task Force and is not intended to reflect the views of each individual member. The composition of this task force was dictated by the nature of this project and its importance to the insurance industry. The Task Force comprises representatives from the entire range of health actuarial practice, including consultants, health service corporation actuaries, health maintenance organization actuaries, and not-for-profit and for-profit insurance company actuaries. The Task Force also obtained assistance from representatives from the Society of Actuaries, staff of national health associations and their member companies. In addition, the Task Force received guidance from staff and regulators from the National Association of Insurance Commissioners.

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TABLE OF CONTENTS

- I. Executive Summary
- II. Introduction
 - A. History
 - B. Issues and Considerations in HORBC
 - C. Simplification Assignments and Definitions
 - D. Process
- III. Simplification of the Risk-Based Capital Formula
 - A. Process
 - B. Annual Statement Blank Changes and Worksheets
 - C. Simplification Proposals
- IV. Sensitivity Testing
- V. Health Care Delivery Assets
 - A. Admissibility and Valuation
 - B. Liquidity versus Valuation
 - C. Valuation Methods
 - D. RBC Implications: Deductive Approach
 - E. RBC Implications: Empirical Approach
 - F. Delphi Approach
 - G. American Association of Health Plans Asset Admission and Valuation Project
 - H. Conclusions
- VI. HORBC Relative Value Factors
- VII. Conclusion

Technical Appendices*

- 1.** September 22, 1995 letter from Commissioner Wilcox
- 2.** November 28, 1995 letter from Chairman Perkins
- 3.** Simplification Proposals and Rationale, Sensitivity
- 4. Recommended Formula as Simplified
- 5. Principal and Secondary Worksheets
- 6. Formula Instructions
- 7.** Annual Statement Proposed Changes and Instructions
- 8.** Sensitivity Test Results (RBC)
- 9.** Summary of State Requirements of Admitted Assets
- 10.** C-1 Delphi Chart
- 11.** American Association of Health Plans Report on HMO Assets
- 12.** Relative Value Discussion

- * The NAIC Working Group received all of the Technical Appendices.
- ** If you would like a copy of the appendices not i cluded in this report, please send a written request to the Academy specifying the appendices you are interested in receiving.

I. EXECUTIVE SUMMARY

The Health Organization Risk Based Capital (HORBC) Simplification Task Force was created to address issues raised by the NAIC in response to the December 1994 report of the original Academy HORBC Task Force.

The Simplification Task Force considered many possibilities in developing simplifications to the HORBC formula, focusing on auditability, specificity, and availability of data. We made substantial reductions in the data required without materially impacting most RBC calculations.

We reviewed the annual statement blanks and developed specific recommendations for data items to be captured on the blanks. These items would be included, or be an audit check on the principal worksheets, which are to be filed with the insurance department (or appropriate regulatory body). The principal worksheets also employ back-up worksheets to be retained at the company. At the same time, we retained the distinctions in the December 1994 formula's recommendation with respect to types of managed care and to most of the product type distinctions.

We changed most of the RBC formula calculations to be based on premiums rather than on other items that are more difficult to audit and obtain, such as life counts and premium equivalent.

We compared RBC levels assumed to be produced under the December 1994 formula and our current recommendations. Although simplification proposals impacted specific companies in various ways, our analysis found that few companies would have their overall RBC level materially impacted by the simplifications.

This report details our findings. Some of these are contained in our preliminary report presented in March 1996. However, important new information has been added, particularly with respect to assets used in the delivery of care and the relative values for the RBC formula.

The NAIC will ultimately establish the level of the Relative Value (RV) factor used in the HORBC formula. We did however determine that an RV factor of between 0.095 and 0.105 produces HORBC answers that roughly match the same level of C-2 RBC as the current Life and Health formula for all carriers in the NAIC database while minimizing the relative change for any one company. We suggest, and NAIC staff has concurred, that the next step in establishing the RV factor is to survey some health carriers to determine the precise HORBC produced for the unique characteristics of a specific company.

We have provided some insight into the issue of health care delivery assets. We completed a survey of current state regulation of the valuation and admission of health care delivery assets for HMOs which showed minor variability across states. Additionally we provide a survey of HMO asset composition and some analysis that suggests that relative RBC adequacy for HMOs is sensitive to the valuation of such assets.



We also offer a discussion of the complexities associated with assessing the risk associated with health care delivery assets and also provide a Delphi survey of Task Force members with their thoughts on possible mapping of health care delivery assets to the current Life and Health formula. This non-quantitative information may be useful as the NAIC further investigates and studies this assets issue while working to implement HORBC.

There are two outstanding tasks that remain on our HORBC work. These include 1), a final check to ensure that the instructions and worksheets are consistent and 2), resolving an outstanding issue on the accumulation of assumed premiums toward the breakpoints in the formula elements where premium volume impacts the determination of the RBC factor.

II. INTRODUCTION

A. History

In 1993, the State Health Committee of the American Academy of Actuaries began to identify risks that health organizations encounter and to recommend an RBC formula which would reflect these risks and that would apply to all types of health organizations. This project was undertaken at the request of the NAIC Health Organizations Risk Based Capital Working Group. The Academy Task Force report was presented to the NAIC in December 1994.

As noted in the December 1994 report, there are a number of RBC formulas that are applied to health organizations. We determined that modifications to the Life and Health RBC formula would be the best approach for the Task Force to take, in order to reflect the unique aspects of health insurance. A related goal of this approach was to begin the process of applying the various regulatory capital measures consistently to different types of health organizations.

During the development of the formula modifications, we took into account many considerations and discussed issues specific to health organizations. These issues generally related to the variability of benefits, pricing and funding of coverages, means of financing and providing covered care, and regulation of the coverages.

The December 1994 Task Force Report addresses these considerations and issues in developing the formula. They are restated in the next section of this report.

The formula modifications recommended in the 1994 report incorporate the wide scope of health coverages, including the prevalence of managed care in many health coverages. They also recognize the large number of funding approaches health organizations offer to their customers as well as the complexities introduced by the use of various reinsurance and corporate structures. Additionally, we considered the wide range of existing premium and valuation regulations and reflected them in the formula modifications.

The range of health coverages encompasses simple indemnity products as well as medical care and loss of income protection coverages. This wide variety of products created a challenge to ensure the consistent assessment of the probability of financial ruin, an essential element for establishing adequate RBC levels.

To achieve this consistency, a single model of the variability inherent in health coverages was created. The model was developed to illustrate the impact of statistical and pricing uncertainties associated with health coverages. The model used claim and loss ratio variability data submitted by carriers providing health coverage. Moreover, assumptions as to profit targets, surplus targets and pricing responsiveness were identified and used in the model for the various health coverages.

The formula modifications recommended in the 1994 report take the form of factors for specific health coverages to be applied to premiums, claims, liabilities or reserves that reflect the risks underlying those coverages. There are credits to the factors where the actions taken by the health organization serve to reduce risk. There are also loads to the factors where the coverage is structured or sold in a way that would increase risk.

The 1994 formula represents risk relativities based on the particular probability of ruin we modeled, but cannot and does not reflect the policy considerations which the NAIC will have to address in choosing the final level of risk based capital.

B. Issues and Considerations in HORBC

As discussed in the 1994 report, these are the major issues regarding the specific formula elements in the HORBC formula. These continue to be the focus of the simplified formula.

Managed Care Credit

The C-2 risk for health coverages, in addition to being the risk of statistical fluctuation, is related to the degree of error in predicting and reacting to the trend in health care costs, utilization, intensity and technology. Traditionally all of these factors have been out of the control of the payor. Consequently, prediction has been largely a matter of extrapolation of past trends.

Some forms of managed care have had a significant impact on the degree of predictability of costs while others have not. Some examples of managed care which reduce risk include approaches which fix prices (e.g. negotiated fee schedules), provider risk sharing (e.g. withholds or bonuses, capitations), and restructure of the cost basis itself (e.g. salaries, negotiated budgets). While there is still risk due to the potential mismatch between the provider contracting period and the pricing period, the ability to negotiate arrangements with providers improves control and predictability. On the other hand, basic utilization management and discounts off normal fees do little to improve the predictability of costs and therefore do little to reduce risk.

The original formula did not provide managed care credits when providers are at risk for services beyond those that they provide directly. They viewed them as comparable to an unregulated reinsurer in this regard.

The approach was to establish the risk associated with traditional health coverages, and then to develop managed care credits to reflect the extent to which managed care arrangements are in place.

Alternate Funding Methods

There are a variety of funding arrangements in use for health insurance. They create unique risks, in that they affect both cash flows and a carrier's ability to reflect cost changes in rates. They also create reporting issues, in that carriers use many different terms and contract provisions to accomplish similar funding arrangements, such as specific stop-loss, aggregate stop-loss, minimum premiums, and ASC.

Reinsurance

When a health insurer cedes a portion of the risk, it has clearly reduced its need for capital to support risk. However, issues arise when the assuming reinsurer may not be able to make good on its risk assumption commitment. Additionally, reinsurance arrangements can be contingent on other actions or results and thereby limit their true risk transfer. Recognizing this, the formula requires that, before an RBC credit is taken, the reinsurance arrangement reflect true transfer of risk and that the reinsurer have a reasonable likelihood of meeting its risk assumption commitment.

General Regulatory Factors

A company's regulatory environment affects the risks it takes, its response time to a deviation of actual results from expectations, and its management decisions regarding risk-taking. Regulation varies from state to state. States have instituted a variety of solvency and guarantee fund regulations.

The RBC formula reflects the impact of rate regulation, solvency regulation and other aspects of the environment in which health carriers operate, such as assessments other than guarantee assessments and valuation variations.

Rate Regulation Environment

There are jurisdictions that do not have the authority to approve rates. Other jurisdictions have the ability to review rate filings, hold public hearings and ultimately approve a rate action different than that proposed by the health insurer. This regulation delays or reduces a health insurer's ability to reflect cost changes in premiums. The impact of this is to put a health insurer's surplus at risk to absorb any premium inadequacy that results.

The model reflected these phenomena by assuming delays in determining cost changes and in reflecting those changes in premiums.

Other Coverages

Other health benefit coverages include long term care, hospital indemnity and cancer policies. These coverages are grouped by their risk of cost and utilization variability. For example, coverages with a fixed schedule of benefits will experience a different pattern of financial results than coverages subject to inflation forces.

Claim Reserves and Liabilities

There is a strong relationship between solvency and the adequacy of claim reserves and liabilities. The original HORBC Task Force discussed the issue of whether a health insurer with reserves in excess of minimum requirements might reduce RBC. The original Task Force did not adopted this since they did not identify an objective measure of reserves' relative adequacy.

There are some health coverages, such as Long-Term Care and Disability Income coverages, for which claims or premiums are not an adequate measure of the risk. These coverages often have claims being paid for long periods of time and beyond the time that premiums are paid. For these coverages, the reserves and liabilities are used in addition to claims or premium to establish a complete measure of the risk.

The original HORBC Task Force did agree that some recognition should be made of companies that obtain a statement of actuarial opinion based on an asset adequacy analysis or that obtain a statement by a member of the American Academy of Actuaries that claim reserves and liabilities are good and sufficient to meet the underlying obligations. The absence of opinions of this type suggest a increased risk of insolvency that should be recognized.

Rate Stabilization Reserve

Many carriers establish funding arrangements intended to avoid large fluctuations in premium levels by maintaining a special reserve which may be legally claimed by a covered group but is held by the carrier and available to cover fluctuations in claim experience. These funds are usually accounted for separately for each employer group. Since these reserves are held to moderate future rate fluctuations, they serve to stabilize financial results and in that way are analogous to RBC. Therefore, they are considered as an offset to RBC. The credit is limited to the RBC of the policyholder to which the reserve is attached.

Affiliated Companies

There are issues that result when companies that operate in the health insurance market are related to other companies that may or may not also operate in the market. The issues include to what extent related companies' assets can be considered to support risks of each company. Also, companies that are affiliated with health insurers but are involved in unregulated businesses create an issue when their assets are used in the unregulated business and therefore, not available to support the health insurance business.



Covariance

The Life and Health Risk Based Capital formula utilizes a covariance adjustment to reflect the fact that many of the risks modeled and reflected in the RBC formula are independent of each other. That is, the probability that all of the risks would have an unfavorable result at the same time is very small. The Life and Health formula based its covariance adjustment on the technical assumption that the probability of ruin mirrored a normal distribution and that the key statistic regarding variability would be the standard deviation. As such, it recognized that the standard deviation of the sum of two independent variables is the square root of the sum of the squares of this standard deviation of each of these independent variables.

The life formula further assumed that the correlation factor between C-4 risk and all other risks was one and the correlation between C-2 risk and C-1 and C-3 risks was zero.

Recognizing the inflation sensitivity of the C-2 risk for certain health products, the Task Force considered whether these assumptions remained valid for health products. The original Task Force determined that insufficient data was available to substantiate any correlation between C-2 and C-1 or C-3 risks. It was perceived that a positive correlation existed between C-2 and C-3 risks and an additional term in the covariance formula recognizing that correlation was contemplated. However, the magnitude of C-3 risk regarding health products is minimal and that additional term would have little influence on the overall result. As such, the original Task Force decided to not recommend any changes to the Life formula covariance adjustment at this time.

However, the Task Force recommends continued research regarding both the appropriateness of the normal distribution assumption regarding probabilities of ruin as well as further research regarding any correlation between the various types of risk.

The original Task Force also discussed recognizing the less than full correlation of C-2 risks from different product lines in a form similar to the Property and Casualty RBC formula. Again, insufficient research existed to provide a viable adjustment within the time frame constraints of this report. As such, although no specific recommendation is proposed, we would recommend the NAIC continue research regarding the appropriateness of such an adjustment and a similar adjustment regarding potentially independent C-1 risks.

C. Simplification Assignments and Definitions

A letter from Commissioner Wilcox dated September 22, 1995 (attached as Appendix 1) requested that the State Health Committee provide additional information and simplifications with respect to elements of the Health Organizations Risk Based Capital Formula.

The State Health Committee contacted all individuals who participated in the development of the original formula as well as other interested parties of the American Academy of Actuaries HORBC Task Force, inviting them to a meeting on November 20, 1995 to review the letter and the approach for responding to the request contained therein. The results of that meeting were

summarized in a November 28, 1995 letter (attached as Appendix 2) from Peter Perkins to Commissioner Wilcox which outlined the process that the Task Force would follow.

The NAIC asked the Academy to modify the formula so that HORBC risk sensitivity was maintained, while identifying areas where obtaining formula input was complicated. The principal goal was to maintain the formula precision but to minimize the cost of collecting and verifying data used. Further, the Task Force strove to provide that the formula would use data that was subject to the criteria defined by the NAIC in their September letter. These criteria are:

- Specificity of Source To the extent possible, data comes from the annual statement. The data can be identified across all types of health carriers and can be expected to have consistent reporting approaches.
- Auditability of Input This is an accuracy criteria and can be achieved by using data from the annual statement as well as balancing detailed data used to summarize data in the annual statement. Additionally, certification of inputs similar to a valuation actuary certification could meet the auditability criteria.
- Availability Data should be that which would reasonably be expected to be produced to manage and report on a health carrier's operation.

The Task Force believes this report meets these three criteria.

First, this report provides a series of HORBC formula simplifications along with appropriate changes to the annual statement blanks. Comments are privded on the relative sensitivity of each of these formula changes along with more structured definition for the inputs to the formula by the use of worksheets and instructions.

Data is available on various structures of health care delivery assets, and for the admission and application of various RBC factors to those assets. This report includes a summary of state variations dealing with the admission of health care delivery assets.

Finally, the report includes a discussion of the relative value factors provided in the original 1994 HORBC formula and a comparison to RBC produced by the Life and Health RBC formula. The simplified formula is included in Appendix 4.

D. Process

The Task Force established three subcommittees to work on the deliverables described above.

First, the Blanks/Reporting Subcommittee reviewed various annual statement blanks. They determined the data that was readily available for inclusion in the 1994 proposed HORBC formula. As part of the process, they identified lines in the blanks that would serve to

be totals to which amounts used to calculate RBC would be required to reconcile. The input structure for the simplified formula was established by this group.

A second group, the Sensitivity Testing Subcommittee, developed models that measured the impact of the simplifications proposed to the December 1994 HORBC formula. They reviewed data from the NAIC database on the current life and health RBC formula for 1500 Life and Health companies. Assuming the premiums shown in the NAIC database were representative of the health premiums that would be used for the December 1994 formula, the report shows the reasonable maximum anticipated impact on total health care risk-based capital from the formula simplifications presented herein.

Finally, the Health Care Delivery Assets Subcommittee performed a process of gathering information to produce some basic health care delivery asset data and to begin to discuss the impact of including HMO health care delivery assets in risk based capital computations.

The Task Force believes that the formula simplifications provide for easily obtained and more readily auditable data, while maintaining the integrity and relative significance of the items that were previously identified by the Academy as important in computing risk based capital for health organizations.

III. SIMPLIFICATION OF THE RISK-BASED CAPITAL FORMULA

A. Process

The Blanks/Reporting Subcommittee first reviewed the data required for the original HORBC formula, and determined that little if any data in the current annual statements would be directly usable with the HORBC formula. The group reviewed the work of the NAIC staff in developing a large supplemental exhibit which would have been necessary if all data for HORBC was to come directly from the statements.

The subcommittee then proceeded to develop proposals to simplify and revise the blanks consistent with the following:

- Items would be added to annual statement blanks which would be used to balance critical totals from the HORBC worksheets.
- Premium totals would balance separately on the basis of direct, reinsurance assumed and reinsurance ceded.
- Claims Paid and Incurred would balance on the basis of direct, reinsurance assumed and reinsurance ceded for each medical or dental line of business.

• Claims Paid and Incurred from the above plus Other Health Claims would balance to Total Claims in other parts of the statements.

The subcommittee adopted a number of proposals while rejecting others. The subcommittee then developed the data requirements and worksheets necessary to accomplish the calculation for the recommended simplified formula consistent with the principles outlined above.

In addition to the simplification changes in the worksheets, instructions are drafted for each of the reporting documents, (including drafting notes) in order to assist in completing the RBC calculations.

B. Annual Statement Blank Changes and Worksheets

The group identified two sets of worksheets. The first set includes three principal worksheets that would be submitted annually to the state insurance department and the NAIC that would include sufficient information to determine the Health C-2 portion of risk based capital. A set of secondary worksheets would also be prepared as necessary but would be retained by the company. These worksheets would be used to develop factors that are used on the principal worksheets and would be available for review by a state insurance department. Key elements on the principal worksheets are to balance to the critical items to be added to the annual statements to meet the auditability requirement. The totals on the secondary worksheets would tie to the principal worksheets and important sections could be verified against company records. These principal and secondary worksheets are attached to this report (Appendices 5 and 6). Appendix 7 provides the items that are recommended to be added to the Annual Statement Blanks.

These blanks changes balance the auditability and availability criteria in that they do not encompass all the data required to complete the HORBC formula. They do provide data to ensure that premium used in the formula is consistent with that reported on the annual statement. They also provide audit checks of some other key elements of the formula such as claims used in the managed care credits and reinsurance ceded and assumed.

The blanks changes are proposed such that they work to be consistent for all health carriers regardless of which annual statement form the carrier files. This supports the NAIC goal of working towards a single reporting format for all types of carriers. This single format goal will require instructions that help the various types of health carriers determine which schedules are required for their business as well as how to complete those schedules.

Finally, the blanks changes that have been recommended are to support HORBC calculation. The NAIC Blanks Task Force is working on proposals to use the information the changes provide in other sections of the various blanks.

C. Simplification Proposals

The Task Force made simplifications based on the criteria established by the NAIC: specificity of source, auditability of input, and availability. The simplifications include overall changes such as computing RBC based on premiums rather than claims in order to enhance auditability.

Other simplifications are more specific and truly simplify the formula. For example, we removed elements that reference minor or non-existing business such as the distinction on dental deductibles greater than \$2,500 and for stop-loss coverages. We simplified the application of the factors by reducing the number of categories (such as stop-loss coverages) or combining coverages (such as hospital indemnity and specified disease coverages). The details of the specific recommendations and the rationale for simplification are included in Appendix 3.

Additional simplifications were considered but did not meet the criteria. They included a two-tier approach to RBC calculation, the elimination of any calculation detail filed with the regulatory agency and a certification by an actuary of a company's RBC level and its relationship to assets. A detailed discussion of these proposals are included in Appendix 3.

IV. SENSITIVITY TESTING

The Sensitivity Model Subcommittee conducted sensitivity tests of the simplification recommendations as described above. The Subcommittee conducted sensitivity tests to determine the impact of the simplifications on specific companies. These tests have generally shown a change in risk based capital compared to the December 1994 proposal which was acceptable to the Task Force. Appendix 8 includes a discussion of the sensitivity tests.

We conducted sensitivity tests in the following areas: combining accidental death and accident only; combining hospital indemnity and specified disease; grading Medicare supplement coverage by premium; condensing the specific stop-loss only table; combining aggregate stop-loss and minimum premium and specific stop-loss when combined with aggregate; employing premium and claim reserve thresholds rather than numbers of lives for disability and long-term care; consolidating rate guarantee periods; and using premium for the rate approval adjustment.

Sensitivity testing was not done on the following simplifications: company-wide medical and dental managed care credits; removing distinction on dental deductible greater than \$2,500 and for stop-loss coverages; health alliance assessments; removing the two-year elimination period for disability and long-term care; reinsurer RBC criteria; reinsurance managed care credits; actuarial certifications. We did not test these simplifications because there was either no impact on the formula (referred to as process simplifications), minimal business under the given formula element, or no valid way to test the simplification due to data limitations.

The subcommittee obtained data from the NAIC data base on the current Life and Health RBC formula. The specific data included: totals of C-1, C-2, C-3, C-4; Health C-2 (including disability, stop-loss, reserves); total adjusted capital; premiums and risk-based capital for each of the companies. No analogous information was made available for other than Life and Health insurance companies. The subcommittee also developed assumptions needed for average premium, average claim, and other items based on actuarial judgement. The Subcommittee determined the maximum reasonable error due to each of the specific simplification proposals and calculated it with the above data to determine the impact on the C-2 portion, and the total RBC after covariance. The Subcommittee compared the change in overall RBC to each individual company to the RBC ratio if the maximum error occurred under the proposal.

V. HEALTH CARE DELIVERY ASSETS

The Task Force was charged with collecting and interpreting information regarding HMO healthcare-delivery (HCD) assets, i.e., the land, buildings, and equipment used by some health organizations to deliver health-care services. This topic embraces a diverse set of assets, from small clinic/office property presumably convertible to general-purpose use if sold, to specialized real estate and furniture (e.g., medical centers (primary care and speciality), outpatient surgery centers, and hospitals), to equipment which may be unusually susceptible to obsolescence.

In considering the RBC treatment of HCD assets, the Task Force reviewed their current financial statement presentation, considered the issue of their liquidity relative to financial assets, and reviewed methodology for their valuation. In the course of these considerations, the Task Force also surveyed empirical literature on HMO solvency and financial impairments.

This section considers only HMO HCD-assets. Other types of organizations use health care related assets to conduct their business. These assets may receive accounting treatment different than that described below. These differences should be considered as the NAIC addresses the HORBC asset issues.

A. Admissibility and Valuation

In general, the statutory accounting for HCD assets follows GAAP accounting. With assistance from the NAIC, the Academy surveyed the state departments that regulate HMOs to determine if and to what degree they admit health care delivery assets. We received responses from 38 departments and found that the vast majority admit these assets at book value. There were a number of states that noted that they do limit the amount of health care delivery assets that can be admitted but further analysis revealed that limits were relatively minor. A summary of the survey results is included in Appendix 9.

The current NAIC model HMO Act permits HMOs to invest an unlimited amount of their assets in land, buildings and equipment for heal⁺h care delivery and for necessary office administration,



and that all permissible investments are fully admitted assets. Section 12 of the NAIC Model HMO Act states that, "With the exception of investments made in accordance with section 5A(1) the funds of a health maintenance organization shall be invested only in accordance with [section of law or regulation implementing the NAIC Health Maintenance Organization Guidelines.]" Section 5A(1) states that the powers of an HMO include "the purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities or both, and their ancillary equipment, and such property as may be reasonably required for its principal office or for such purposes as may be necessary in the transaction of the business or the organization."

One recent accounting development that is applicable to the Task Force's work has been the Financial Accounting Standards Board's Statement 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of." Statement of Financial Accounting Standards (SFAS) 121 sets standards and requirements for evaluating and recognizing the impairment of value of assets. Under the new rules implemented in January 1996, all companies must review long-lived assets to determine whether their value may be impaired "whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable". For staff- and group model HMOs and other integrated delivery systems, these assets include hospital and medical offices. HMOs must "write down" their investments in fixed assets to the lower of depreciated cost or fair value.

The Task Force is aware of the significant potential for statutory accounting change which may emerge from the NAIC's current Codification of Statutory Accounting project. Task Force members feel that an HORBC formula, in particular the formula's definition of Total Adjusted Capital (TAC), must be flexible enough to disallow (or reinstate) for RBC purposes assets which are relevant to RBC but which are admitted (or nonadmitted) for other statutory accounting purposes. This position is consistent with that adopted for other RBC formulae, e.g., the reinstatement of Asset Valuation Reserve (AVR) amounts to the TAC of life insurance companies.

B. Liquidity versus Valuation

The Task Force has received comments to the effect that HCD assets' relative illiquidity renders them a unique risk exposure, the risk charge for which should be substantial. The Task Force has considered these comments and does not find them persuasive. Rather, some Task Force members distinguish between liquidity issues (which may cause, in accounting parlance, "temporary" reductions in realizable value) and valuation issues ("other-than-temporary" reductions). This is because these operating assets are used primarily to meet the obligation of providing health care services to members, rather than as an investment asset used to generate revenue to pay cash claims. These members argue that the foreseeable reduced realizable value of an insolvent health organization's HCD assets is primarily a function of those assets' diminished, post-insolvency utilization. The Task Force received suggestions and discussed establishing a liquidity test, or measure, for health carriers, particularly those with significant investment in health care delivery assets. The Task Force determined that liquidity is related to, but different from, solvency. That is, a carrier may be solvent but have illiquid assets, and thus be subject to significant liquidity risk. With this, the Task Force felt that liquidity risk assessment was outside the scope of the HORBC simplification process. The Academy, at the request of the NAIC's Risk Based Capital Task Force, is undertaking a separate assessment of the need for minimum requirements with respect to liquidity.

C. Valuation Methods

Financial statement values of real estate, furniture, and equipment are ordinarily the lower of amortized cost or fair value. The fair value of these "hard assets" is customarily assessed under three methods: replacement cost, market value, and earnings capitalization. Task Force members agree that replacement cost is not a theoretically meaningful method in the context of solvency regulation. Conversely, the market method (i.e., comparison of the asset with recent sales of like assets), suffers from a practical shortcoming: sparse data; in any given geographical area, relevant comparables are likely to be few, and therefore provide little statistically valid information. Ultimately, the fair value of HCD assets appears to us to be a function of the present value of the assets' future earnings stream (i.e., their utilization) plus disposal value. We note without further comment that this conclusion is consistent with the concepts underlying SFAS 121.

D. RBC Implications: Deductive Approach

The RBC treatment of any exposure is governed by three considerations:

the nature of the risk;

the magnitude of the risk; and

the relationship of the risk to others faced by the enterprise or to the overall "enterprise risk."

The statutory accounting for and financial-statement valuation of HCD assets, while not determinative of the proper RBC treatment, are nevertheless illuminating. Specifically, the valuation rationale above illuminates theoretically the nature of the risk and thus, to some extent, its relationship to other risks.

If the value of HCD assets is primarily a function of the enterprise's expected future utilization of those assets, their value will ordinarily not fluctuate significantly, independent of the activities and fortunes of the health-care enterprise as a whole. Conversely, the adverse impact of an enterprise's insolvency on HCD-asset utilization will have a significant impact on asset value, an impact which simultaneously affects the enterprise's net worth.

Theoretical HCD-asset-risk behavior is therefore fundamentally different from asset risk as contemplated in insurance literature (i.e., the traditional C-1), where the principal assets and investments fluctuate continuously (at least at the overall portfolio level) as a result of external events. Traditionally, the insolvency of the insurer would thus not affect the value of its portfolio, and the asset value available in an orderly liquidation would be reasonably approximated by a financial statement value immediately prior to the insolvency. HCD-asset values, on the other hand, may be expected to change discretely, or nearly so, upon the fact of the insolvency; the financial statement values for such assets immediately prior to insolvency are thus likely to represent an overstatement of the value available to the liquidator. It is this dynamic that SFAS 121 is intended to address.

From the above, the Task Force reasons that HCD-asset risk would be unlikely to independently and significantly affect an otherwise healthy enterprise's probability of ruin: value impairments arising from underutilization would become a notable solvency risk only for enterprises that are already financially stressed. (Note, however, that the resulting asset write-downs may be the first full financial-statement recognition of such financial stress.) Correspondingly, the Task Force concludes that HCD-asset risk likely aggravates the degree of an insolvency once the insolvency has been triggered.

E. RBC Implications: Empirical Approach

The Task Force also sought empirical information to evaluate the relationship of C-1 risk to HCD assets. A subgroup surveyed the literature on health organizations' solvency and reported to the full Task Force. The report indicated: (1) the empirical literature is sparse; (2) the definitions of financial impairment used in the literature vary; and (3) what empirical data exist suggest that asset risk generally and HCD asset risk specifically have rarely if ever been cited as the principal cause of a health organization's financial impairment.

The literature suggests the Task Force's view of HCD-asset risk's impact on the probability of ruin is correct. In light of the sparse data and the definitional ambiguities, however, the Task Force views the literature as not contradictory of these conclusions, rather than as confirmatory. Several Task Force members believe further study is necessary before the empirical evidence may be regarded as confirmatory.

The absence of hard data on insolvency-related asset writedowns leaves the Task Force with no basis from which to statistically derive an RBC factor. The HCD-asset risk represents a large enough part of an HMO's overall risk that further quantitative study of the phenomenon is necessary to establish an RBC factor which is anything other than merely expedient. In the absence of such a statistical database, however, the Task Force recognizes that approaches such as the Delphi method, described below, may need to be employed for interim regulatory solutions.

The Task Force is also cognizant of the fact that what empirical evidence exists covers the time period preceding the effective date of Statement of Financial Accounting Standards 121. The imposition of new standards and requirements for writedowns, arising from SFAS 121, may have a significant effect on the conclusions as to HCD assets' impact on the probability of ruin and the severity of the insolvency, as organizations may tend to recognize HCD-asset impairment earlier than in the past. For this reason, too, the Task Force urges continuing study.

The study of the variability of health care delivery assets should be coordinated with the historical data used in the original modeling for HORBC because the historical data obtained from HMOs were changes in HMO surplus and not changes in loss ratios. Thus the historical variability observed for HMOs would have included changes in asset values. However, the data from the original modeling included only HMOs which were still operating and thus exclude insolvent HMOs.

F. Delphi Approach

The Academy coordinated a survey of the Task Force members to gather opinions on the similarity of HMO health care delivery assets and asset categories used in the Life and Health Risk Based Capital formula. Seven of the members responded to the survey. Appendix 10 is a summary of the responses.

When forced to match health care delivery assets to Life and Health RBC asset categories, the survey respondents recognized that most HMO health care delivery assets are similar to life and health insurance assets that are used to deliver services or pay insurance claims. Thus, most responses suggested that HMO health care delivery assets are similar to either cash or company-owned and occupied real estate since both are used for satisfying claims. These asset types have different risk characterics.

The survey and responses are intended to give the NAIC working group some subjective input on the mapping of HMO health care delivery assets to the Life and Health RBC formula. This type of an approach may be useful in light of the complexity of the health care delivery asset risk issues and the short time available to analyze and quantify them.

G. American Association of Health Plans Asset Admission and Valuation Project

The Academy sought the assistance of the American Association of Health Plans (AAHP) regarding the admissibility and valuation of assets in the proposed risk-based capital (RBC) formula for health organizations. AAHP represents more than 1,000 health maintenance organizations (HMOs), preferred provider organizations (PPOs), utilization review organizations (UROs), and third-party administrators (TPAs) nationwide.

In response to the Academy's request for data on HMO assets used in health care delivery and administration, AAHP retained the actuarial firm Milliman & Robertson (M&R) to conduct a

comprehensive analysis. The Academy worked with AAHP and M&R representatives to design a spreadsheet used for data collection. A database was developed that shows the distribution of health care delivery assets. The database illustrates the relationship between various levels of asset value recognition and the RBC factors. The entire report is in Appendix 11. One hundred and thirteen HMOs from 39 states provided AAHP/M&R with comprehensive income and asset data from their 1994 HMO Annual Statements ("Orange Blanks"). The HMOs in the sample had 22 million members, or 43% of all HMO enrollees in the U. S. as of December 1994.

The study shows the wide variety of asset composition across the HMO industry, with some HMOs having very little HCD assets and others having a significant amount of HCD assets. Additionally, the study clearly demonstrates that the asset valuation basis has a dramatic impact on regulatory intervention requirements by states for HMOs with significant assets in land, buildings and equipment.

Since this data was drawn from HMO annual statements, it may not be representative of the financial structure of other managed care organization, such as Provider Sponsored Organizations. Some of these organizations have significant health care delivery assets but may only have a small amount of insured health coverage. In discussing these types of organizations, the Task Force considered two approaches. First, the organizations may consider establishing and capitalizing a subsidiary licensed to accept the insured risks which would be subject to HORBC and other insurance regulation. Second, the NAIC may consider establishing a means to identify and establish assets of the organization that are dedicated to supporting the insurance risk. The former approach is consistent with current corporate and regulatory approaches while the latter is more unique and would require further study and discussion to implement.

H. Conclusions

The Task Force reached several conclusions:

- A wide variety of asset structures exist within health organizations.
- Admission and valuation of HCD assets can have a significant impact on the Total Adjusted Capital and RBC.
- There is a risk associated with the fluctuation in HCD-asset values that is appropriate to address within the RBC framework.
- The nature of HCD-asset risk differs from classic C-1 asset risk in that it appears to increase the probability of ruin less, but increase the severity of ruin more, than classic C-1 risk. SFAS 121, which requires timely recognition of asset-value impairment based upon expected future asset utilization, may be expected to move HCD-asset risk' probability/severity profile more closely to the profile of classic C-1 risk.



- HCD-asset risk also differs from classic C-1 risk in that it is not independent of the other risks faced by the company. Rather, it appears to be correlated with the overall risk.
 - The magnitude of HCD-asset risk, to the extent there can be a single magnitude for so varied a topic, is not determinable with statistical confidence from data currently available. Further study is required. In the interim, some expedient method, perhaps derived by analogizing to other asset classes, may be required.

While this report discusses many of the issues surrounding the treatment of health care delivery assets, the report does not address certain key issues that the NAIC must decide.

- Consistency in the treatment of all health carriers. The Academy's studies have not attempted to compare the proposed treatment of health care delivery assets used in certain types of health carriers with the already mandated treatment of similar assets in other health carriers.
- The proportion of assets in one category. The Task Force did not attempt to examine the potential for additional risk created by a concentration of health care delivery assets as a percentage of total assets.
- The proportion of assets in one asset. The Task Force has not attempted to look at the ٠ additional risk created by a concentration of assets within one specific asset even if it is a health care delivery asset.

We urge the NAIC to examine these issues as they finalize the HORBC formula.

VI. HORBC RELATIVE VALUE FACTORS

The Task Force compared the current Life and Health RBC formula C-2 levels to those produced by the proposed simplified HORBC formula. This can be accomplished using three approaches:

- Compare assumed industry-wide C-2 risk distributions;
- Compare assumed company C-2 risk distributions;
- Compare sample or surveyed C-2 risk distributions.

The Task Force undertook to provide information on the relative value included in the HORBC formula. To provide this information, we focused on the C-2 risk component under the current Life and Health formula and the proposed HORBC formula.

Our testing focused on medical coverage, and was based on 1994 NAIC data for premiums and RBC values. The testing shows that an RV of 0.1053 reproduces the total Life and Health RBC for C-2 under the current formula in aggregate, with some variation by company in the sample.



Further tests show that an RV of 0.0946 minimized the mean square error. The original HORBC formula used an RV of 0.09 to represent a 5% probability of ruin.

We conducted tests for other coverages. These tests indicated that the sensitivity of RBC to RV levels can be significant for certain coverages, and is generally going to increase RBC for smaller lines of coverage, and decrease RBC for larger lines.

Details on the test results are available in Appendix 12.

Note that the Academy does not recommend a specific level for RBC. The NAIC should determine the appropriate level based on its assessment of a desired probability of ruin, considering the information supplied by the Academy in our reports and other information.

VII. CONCLUSION

The Academy is pleased to present the results contained herein to the NAIC Working Group. We believe that the attached formula modifications represent an opportunity to simplify the HORBC recommendations. In most instances the simplifications have a modest impact on specific risk-based capital levels for a company or organization. In some of the more "leveraged" businesses, such as stop-loss coverage, the change is more significant. The NAIC may want to consider requesting additional information during the first few years when the HORBC formula is used to determine the actual premium to premium equivalent ratios involved in stop-loss coverage. These proposals do, however, still present a less complex method of determining a risk-based capital value that is within the range of the original proposed 1994 HORBC formula.

It is important to point out that the Academy has not tested the overall formula on actual company data. We recommend that the NAIC test this formula against data for specific companies to validate the levels and observe how unique company characteristics are treated in the formula.

The health care market is rapidly evolving, and the Task Force suggests that a regular review of the elements and effectiveness of the formula be conducted.

There are two outstanding tasks that remain on our HORBC work. These include 1), a final check to ensure that the instructions and worksheets are consistent and 2), resolving an outstanding issue on the accumulation of assumed premiums toward the breakpoints in the formula elements where premium volume impacts the determination of the RBC factor.



Risk based capital is calculated as in the Life RBC formula. The following are changes to be made to that formula. The changes are discussed as they relate to C-2 risk and C-4 risk, and some changes to the basis of reporting are suggested.

I. C-2 Calculations for A&H Morbidity

All premium values must be separated into direct earned premiums or earned subscriber revenue, reinsurance assumed or reinsurance ceded. An index adjustment I is defined as: (CPI-M for July 1 of the year under discussion) divided by (CPI-M for July 1, 1994). Most RBC values are calculated separately for these parts using different factors. "RV" in this formula represents relative value units.

[DRAFTING NOTE: For reporting purposes, supplemental worksheets will be used for certain specific calculations. Where the supplemental worksheets instructions are not followed completely, they would be allowed with an actuarial certification. This would apply where information required was either: i) detailed, ii) confidential, or iii) not available and estimated. In any of these situations, an actuary could certify that the work done is a fair representation of the position of that particular company with respect to the formula. Generally, a certification would include a statement that the technique used produced a similar and more conservative result, and would include a description of the method used to verify the result, and a description of any estimation techniques.]

A. Medical Coverage

1. Risk Factor [C2 Principal Worksheet Premium, Line 1.1]

This section is intended to encompass all medical coverages not otherwise addressed in this formula. This includes medical coverage with deductibles for an individual up to \$2,500. Coverages with higher deductibles are covered under stop-loss, if such deductibles form a substantial portion of the block of business. For individual coverage, "substantial" means that the ratio of premium for coverage with deductibles over \$2,500 to premium for all individual medical coverage exceed 15%. For other than individual, any premium is considered substantial. C x I + (1.00 minus Total Managed Care Credit Factor, if any) x RV x (Premium x Loss Ratio), but not less than $0.000 \times I$,

Where C is the smaller of (\$1.5 million) or (2 times the maximum retained risk after reinsurance on any single life.)

2. Managed Care Credit [Worksheet 1.1]

Payments made under managed care arrangements which meet the following definitions are used to calculate a C-2 credit. Credit can be made under only one category for each dollar of payment. If payments are eligible for more than one category of managed care credit, the carrier may choose which category to use for the calculation. Payments should be split according to the category into which they fall in the following table.

"Factor credits" (column f) in the following table are to be applied to the corresponding "\$\$ paid" (column e) by category of care.

	Category of Managed Care	\$\$ Paid	Factor Credit	Pro- duct
	(a)	(e)	(f)	(g)
1	Payments made at levels set by contractual agreements.		15%	
2	Payments made subject to withholds or bonuses.		XX1	
3	Capitation payments made to entities directly providing medical care, for care directly provided.		40%	
4	Non-contingent salaries or aggregate cost ² payments, when paid directly to persons licensed to provide medical care. ³		50%	
5	None of the above. (Remaining dollars paid that are not included in one of the categories above.)		0%	

¹A factor determined by the formula described in worksheet 1.1 with a maximum of 25%.

²The "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. The aggregate costs to be put in this chart equal the payments of the last year, less the largest deviation of actual cost from budgeted in the last five years.

³This item will include salaries paid to doctors and nurses whose sole corporate function is utilization review.

	Category of Managed Care	\$\$ Pald	Factor Credit	Pro- duct
6	Total			
7	Total Managed Care Credit: 6(g) divided by 6(e). (Apply to the underlying coverage x C-2 RBC amount.)			

[DRAFTING NOTE: The types of managed care in the table are generalizations of the many managed care arrangements which are possible. Any combination of facility, professional, drug, or other medical delivery component might be contracted for on any combination of a scheduled, capitated, salaried, or other basis. This complex and changing environment creates a challenge in establishing the managed care types for both creating an RBC formula and for a health plan completing an RBC calculation and may require judgement. As managed care practices emerge, catergories should be reassessed by the NAIC on a regular basis.]

B. Alternative Funding Methods

For calculations in B.1. and B.3., the managed care credit factor should be used. [Worksheet 1.1]

1. Direct Specific Stop-Loss for Medical Coverages [C-2 Principal Worksheet Premium, Line 1.2 and Worksheet 1.5 Section A]

This section will include premiums for medical coverage with deductibles of \$2,501 or more, including hospital benefits but excluding dental coverage in Line 1.2. In Worksheet 1.5, the risk based capital calculation in Section A is to be applied to cases with direct specific stop-loss only (i.e., not written in combination with aggregate stop-loss). Cases with aggregate stop-loss should use the procedures in Section I.B.3.

[DRAFTING NOTE: Cases with both aggregate and specific stop-loss may need to identify the appropriate specific stop-loss factors from the table in Section I.B.1. for use in the table and procedures described in Section I.B.3.]

Risk based capital is calculated as actual premium under these arrangements, times the following factors:

Deductible or Attachment Points	Factor	
Less than or equal to \$100,000	1.67 RV	
Greater than \$100,000	2.78 RV	

2. Direct Specific Stop-Loss for Coverages Other Than Medical Coverages

Risk based capital is calculated as actual premium under these arrangements, multiplied by the following factors. Elimination period or dollar amount attachment points will determine the factor.

Attachment Points				
Elimination Period	Dollars	Factor		
Up to and including two years	Less than or equal to \$100,000	1.11 RV		
Over two years	Greater than \$100,000	1.85 RV		

This section applies to non-proportional reinsurance for disability income and long-term care except that Section H applies to claim reserves established for such policies.

This section applies to coverage with only direct specific stop-loss (i.e., not written in combination with aggregate stop-loss). This section applies to coverage with both aggregate direct specific stop-loss and aggregate-only coverage. For coverage with both, the appropriate factor for specific must be determined from the table and procedures in Section I.B.3. For aggregate-only stop-loss, the factor should use the largest specific stop-loss factor from the appropriate table.

3. Aggregate Stop-Loss and Minimum Premium [Worksheet 1.5 Section B]

Coverage	ASL Factor	
Groups with 50 lives or <110% ASL attachment points	1.5	
All other	1.075	

Except where noted, the C-2 element for such arrangements is calculated using actual stop-loss premium.

Medical Coverage ASL Only:

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(Aggregate Stop-Loss Factor) x 2.78 RV x (ASL Premium)

ASL with SSL:

(Aggregate Stop-Loss Factor) x (Specific Stop-Loss Factor) x (Total Stop-Loss Premium)

Non Medical Coverage ASL Only: (Aggregate Stop-Loss Factor) x 1.85 RV x (ASL Premium)

4. Administrative Service Contracts [C-2 Principal Worksheet Premiums, Line 9, C-2 Principal Worksheet-Other Risks, Line 0.3]

0.056 RV of the premium, or premium equivalents (charges plus claims) depending on reporting basis.

[DRAFTING NOTE: To provide a level playing field between licensed insurers and third party administrators, it may be appropriate to adopt a comparable risk based capital standard for such administrators.]

[DRAFTING NOTE: Refer to the NAIC rules of usage of premium and premium equivalents for reporting purposes.]

[DRAFTING NOTE: Administrative Service Contracts are contracts that are funded as administrative services only, or self insured, but for which: (1) the carrier pays claims from its funds and subsequently receives reimbursement from the contract holder and (2) the certificate holders, or employees' coverage card has the carrier's name and logo on it.]

5. Minimum Capital (C-2 Principal Worksheet Premiums)

If the value of C calculated under I.A.1 would be increased based on the retained amounts under I.B.3, the higher value of C should be used.

C. Adjustment for Environmental Factors

1. Assessments Other Than Guarantee Fund Assessments [C-2 Principal Worksheet-Other Risks, Line O.1]

The RBC factor for this element of risk is equal to the absolute value of: (the highest percentage assessment in the prior three years as a percentage of premium, not including Guaranty Fund Assessments) minus (the lowest such percentage in the last three years) multiplied by medical premium. If three years' assessment experience is not available, two years' experience should be used.

[DRAFTING NOTE: This is intended to reflect the risk that assessments will vary from period to period. This variability makes estimation and inclusion of these assessments into premiums and charges a risk factor. By using the difference between the highest and lowest assessments in the latest three years, the fluctuation in assessments, rather than their average values, will drive the size of the risk factor. This amount should not exceed the absolute dollar difference in assessments paid.]

[DRAFTING NOTE: The assessments used in this calculation are those assessments required to be paid by the insurer relative to health insurance and health insurance only (e.g. high risk pools, demographic pools, assessments for losses in other markets, risk adjustment, or assessments from health purchasing pools or alliances such as adminsitrative expenses, risk adjustment, and losses) other than assessments paid to medical providers. These arrangements can be state run or not. Assessments used in this calculation include reimbursements that the insurer is obligated to pay in order to maintain membership in the arrangement, or to continue to insure applicants through a pool or other arrangement. This calculation includes amounts as a negative assessment received by the insurer from such arrangements. Exclude assessment for Guarantee Funds or Guaranty Associations.]

[DRAFTING NOTE: The Task Force believes that community rate laws and their parallel risk adjustment mechanisms can be a significant risk, particularly within the first few years of introduction.]



C-2 risk based capital from health insurance is multiplied by 1.20 if the company's annual statement does not include a statement of actuarial opinion that the company's premium, policy, and claim reserves and liabilities are reasonable, and that they include appropriate provision for all actuarial items that ought to be established.

[DRAFTING NOTE: The Task Force believes that with current state regulation of health insurance reserves, the possibility of inadequate but legal reserves could be a significant risk. Therefore, a Section 7 opinion (of the NAIC model valuation regulations) is not as high a standard as the above opinions would be. It is intended that a Section 8 opinion would be one way to meet the above standard.]

D. Other Health Coverages

Other health insurance coverages are subject to the following risk based capital levels. Factors, unless otherwise noted, are to be multiplied by the net earned premiums for that coverage.



- 1. Dental Insurance [C-2 Principal Worksheet Premiums, Lines 2.1 and 2.2]
 - a. \$125,000 x I + 0.78 RV x (direct less ceded premiums) x (loss ratio)
 - b. Managed Care Credit: [Worksheet 2.1]

The managed care credit factor, separately calculated for dental but using the same categories as 1.A.2, should be applied to the RV factor above, but not to the flat amount.

- c. Reinsurance assumed premiums do not receive any managed care credit factor reduction.
- 2. Medicare Supplement: [C.2 Principal Worksheet Premiums, Line 3]

\$50,000 + 0.68 x RV x (premiums) x (loss ratio) x (1-Managed Care Credit for Medical Coverage)

3. All Accidental-Only Coverage [C-2 Principal Worksheet Premiums, Line 4]

C + 0.6 x RV on the first \$10 million of earned premium + 0.25 RV on the excess earned premium.

Where C is the smaller of \$300,000 or 3 times the maximum retained accidental death risk after reinsurance on any single life.

4. Cancer and Other Specified Disease Coverages and Hospital and Intensive Care Indemnity: [C-2 Principal Worksheet - Premiums, Line 5]

\$50,000 + 0.354 RV x earned premium.

5. Credit Disability Income: [C-2 Principal Worksheet-Premiums, line 6.1-6.3]

1.26 RV x premium. For single premium credit disability, where unearned premium reserves exceed 50% of earned premium, a credit of 0.05 RV of such excess divided by total earned premium can be applied to reduce the factor otherwise applicable, to a limit where the net factor is not less than 0.8 RV.

[DRAFTING NOTE: The method of computing unearned premium reserves for single premium credit insurance is based on gross premiums. This reserve methodology results in a substantial overstatement of the liability for claims. This overstatement also represents a substantial margin for absorption of claim fluctuations. Accordingly, the C-2 factor should be and has been adjusted by reducing the C-2 percent of premium factor by a percent of the excess unearned premium reserve. While a similar

overstatement of unearned premiums exists for certain other health coverages, the magnitude is not nearly as significant as it is for single premium credit disability.]

- 6. Disability Income: [C-2 Principal Worksheet-Premiums, Lines 7.1 to 7.4]
 - a. All premium is subject to factors of 25% of the first \$12,500,000 and 10% of the excess.
 - b. Premium for disability income with benefit periods of 24 months or less receive a credit of 25% (to reflect reduction to 75% of maxmium RBC value) applied at the marginal rate.
 - c. Premium for reinsurance ceded under extended wait reinsurance (nonproportional) which reduces the company's exposure from over 24 months to 24 months or less allows a credit comparable to that provided in (b).
 - d. Premiums for reinsurance assumed under extended wait reinsurance must offset credits taken by the ceding company.
 - e. Minimum Level:

The application of formulae a. through d. above, is subject to a minimum RBC factor equal to three times the maximum benefit amount exposed per life, being the largest monthly income or benefit amount retained per life insured, net of reinsurance, multiplied by the longest benefit period in force, not to exceed 100 months.

- 7. Long-Term Care Insurance: [C-2 lines 8.1 to 8.4]
 - a. All premium is subject to factors of 25% of the first \$25,000,000 and 10% of the excess.
 - b. Premium for long-term care with maximum benefit periods of 24 months or less receives a credit of 25% (to reflect reduction to 75% of maxmium RBC value) applied at the marginal rate.
 - c. Premium for reinsurance ceded under extended wait reinsurance (nonproportional) which reduces the company's exposure from over 24 months to 24 months or less allows a credit comparable to that provided in (b).
 - d. Premiums for reinsurance assumed under extended wait reinsurance must offset credits taken by the ceding company.

e. Minimum Level:

The application of formulae a. through d. above, is subject to a minimum RBC factor equal to three times the maximum benefit amount exposed per life, being the largest monthly income or benefit amount retained per life insured, net of reinsurance, multiplied by the longest benefit period in force, not to exceed 100 months.

8. Other Health Coverages: [C-2 Principal Worksheet - Premiums, Lines 9.1 and 9.2]

For coverages where premiums are subject to inflationary trends: 1.5 RV. For coverages where premiums are not subject to inflationary trends: 1.25 RV.

[DRAFTING NOTE: The "subject to inflationary trends" language is intended to be consistent with the Life RBC formula. However, it is subject to substantial interpretation. Therefore, as products emerge as material to RBC, the Task Force believes the best regulatory approach is to treat them explicitly in the formula as separate categories.]

9. For At-Risk Medical Contracts, the appropriate Medical Coverages factors (Section I.A. above) should be used.

[DRAFTING NOTE: Examples of these are Medicare and Medicaid at risk contracts.]

- E. Adjustment for Limits on Premium Movement
- 1. Rate Filing and Process Adjustment [C-2 Principal Worksheet Other Risks, Line O.2.d; Worksheet O.2d]

This section does not apply to accident only, hospital indemnity, cancer, disability income, long-term care, Medicare supplement, and other non-inflationary coverages. This section does include other medical coverages, dental coverages, and Medicare and Medicaid at risk contracts.

The degree of additional risk varies with the timeliness of the carrier's response to the need for changes in premium for inflation-sensitive health coverage.

a. Where premiums are allowed to change automatically for an approved trend adjustment:

0.092 RV x (premiums subject to prior approval of trend) x (1-company's managed care credit factor)



b. Where premiums are not allowed to change without prior approval, the company may use an average factor applied to the total such premium:

0.184 RV x (premium subject to prior approval of any increase) x (1company's managed care credit factor).

An alternative is to split the premium from E.1.b. into that portion for which rates were revised within the past 24 months and approved as filed within 45 days of filing (and within 120 days of the end of the experience period used in developing the rates. For this portion of premium:

0.092 RV x (premium meeting specifications) x (1-company's managed care credit factor)

The balance of the premium from E.1.b.:

0.46 RV x (balance of premium) x (1-company's Managed Care Credit)

[DRAFTING NOTE: The Rate Approval Adjustment reflects the longer time frame needed to implement rate actions implicit in "prior approval" and public hearing situations. The Task Force believes this to be an important and valid risk factor.

If this element is removed, further thoughts should be given to reflect that this factor includes some of the difference in risk between individual and group coverages.

An adjustment for the risk of ill-defined "premium caps" discussed under various reform proposals might be appropriate, depending on the political environment as health care reform unfolds. However, more definition must take place before the risk can be modeled or evaluated.

The Task Force intends that Medicare risk contracts and coverage of Medicaid enrollees are coverages to be subject to the above rate approval adjustment, where such rates are subject to prior approval by state or federal authorities, even though perhaps not the Commissioner.]

- 2. Premium Guarantees [C-2 Principal Worksheet-Other Risks, Lines O.2.a & b, Worksheet O.2a]
 - a) For medical, dental, Medicare supplement, and other inflationary coverages where there are either (1) explicit or implicit premium rate guarantees or (2) premium rates implemented on policy anniversaries beyond the next anniversaries (rather than premium due dates), the premiums are subject to the following factors:



b) For non-cancelable premiums reported in the statutory statement:

25% for non-cancelable premiums up to \$12.5 million, plus 10% for non-cancelable premiums for the excess

3. Performance Guarantees [C-2 Principal Worksheet-Other Risks, Line O.2.c; Worksheet O.2c]

Where such guarantees exist outside of an insurance contract, there is an additional RBC factor of 30% of the amount at risk under the contract in the current contract year.

4. Guarantees and Process Adjustments for Reinsurance

Where (1) the direct writer has additional RBC for rate approval and rate guarantee adjustments and (2) the reinsurance contract limits the reinsurer's rights to change premiums or benefits to match changes by the direct writer, reinsurance ceded credit against these additional RBC amounts is allowed.

F. Reinsurance Credit

A credit is allowed for certain types of reinsurance.

1. Quota Share or Proportional Reinsurance [C-2 Principal Worksheet Premiums, Line 10; Worksheet 10]

The reinsurance credit is the percentage of risk reinsured multiplied by the C-2 RBC calculated above. This is subject to:

- a. For coinsurance of excess indemnity, where the reinsurance percentage varies for different policies depending on the amounts of insurance in force for those policies, the percentage of risk reinsured is the total reinsured amount divided by the total direct amount.
- b. The percentage of risk reinsured is applied after adjustments for managed care credits.


[DRAFTING NOTE: The intent of the managed care credit limitation is to recognize that direct writers are unlikely to reinsure capitated coverages.]

- c. Reinsurance credits under this section apply to percentage factors only, and not to flat amounts.
- 2. Non-Proportional and YRT Reinsurance [C-2 Principal Worksheet-Premiums, Lines 1.3, 3 through 9 and Worksheet 1.3]

A reinsurance credit is determined as follows:

(185% of ceded premium) x (the appropriate RBC factor).

A credit as approved by the Commissioner of Insurance of the state of domicile.

All credits in this section are subject to the same managed care credit factor, where applicable, used in the direct calculation.

- 3. Qualifications for Credit [Worksheet 1.3 and 10]
 - a. Reinsurance credits can be taken only where:

(1) the reinsurance arrangement meets the NAIC definition of reinsurance,

(2) there are no contractual limits, or terms, to diminish the losses of the reinsurer. If such limits to the reinsurer's losses do exist, any credit must be approved by the Commissioner of the direct writer's state of domicile,

and (3) the contract is renewable by the direct writer to the end of the underlying period of coverage on policies being reinsured.

b. Such credit can only be taken to the extent that credit is allowed by the state of domicile for the purposes of a regulatory financial statement.

[DRAFTING NOTE: In addition to this requirement, the NAIC may want to reference the state's credit for reinsurance statute, which is required under the NAIC Accreditation Program.]

G. Application of Size Scales

[C-2 Principal Worksheet Premiums, line 12.8]

Coverages that include an RBC with a fixed amount should have total C-2 risk reduced by 75% of the sum of all but the highest fixed amount.

H. Claim Reserves and Liabilities

[C-2 Principal Worksheet-Other Risks, lines O.4a through O.4c]

1. For all disability income coverages, other than credit disability, claim reserves and liabilities are subject to a factor of:

(0.04 x reserve) + [0.06 x the lesser of (\$35million or the reserve)] - [0.06 x STR x the lesser of \$20 million or the greater of (reserve - \$15 million or zero)]

where STR= short-term ratio, the ratio of the short-term disability premium (line 7.2 of Principal Worksheet) to all disability premium (line 7.1).

- 2. For credit disability income coverages, claim reserves and liabilities are subject to a factor of 10% of net claim reserves under \$7.5 million and 4% of the excess.
- 3. For long-term care coverage, claim reserves and liabilities are subject to a factor of 10% of net claim reserves under \$15 million and 4% of the excess.

I. Credit for Rate Stabilization Reserves⁶ Retrospective Premiums and Dividends

[C-2 Principal Worksheet-Other Risks, line 0.5; Worksheet 0.5]

Where a rate stabilization reserve is available for use by a health organization to cover losses from any policy in any line of business, a credit of 100% of the reserve can be taken.

Where a rate stabilization reserve is held for the benefit of a specific policy or group of policies, a credit of 100% of the reserve can be taken, but does not have to be taken,

⁶Rate stabilization reserves, for this purpose, include amounts which: (1) appear on the company's liability page, (2) are available for use by the company to offset unexpected losses and are not required to cover anticipated losses, and (3) are not required to be held in order to satisfy other statutory obligations such as valuation law. They do not include reserves held for retired lives and gross promium valuation reserves.

up to (1) the full amount of C-2 risk based capital attributed to that group of policies, less (2) P% of premium. (For this purpose, risk based capital attributed is calculated by calculating the total C-2 risk based capital with and without such policies, and taking their difference.)

Where the policyholder is an agency of the federal government, where that agency holds a rate stabilization reserve, and where there is contractual language which puts such a reserve totally at risk to pay for premium shortfalls, such reserve will be treated as though the insurer were holding the reserve.

Where (1) a contract exists requiring the policyholder to pay additional premiums to cover losses under an experience rated contract, and (2) the prospective premium for each policy (before application of the additional premiums) has been certified by a Member of the American Academy of Actuaries to be self-supporting, then a credit equal to the additional premium may be taken up to:

- (1) the full amount of the C-2 risk based capital attributed to that policy, less
- (2) P% of premium, with a minimum of 1%, if the amount of the retro is not secured by a letter of credit or funds on deposit with the health organization.

Where such a contract exists but prospective premiums are not self-supporting, then the contract should be treated as aggregate stop-loss coverage.

Dividends paid to policyholders are treated similarly to retrospective premiums with a credit equal to dividends paid up to (1) the full amount of C-2 risk based capital attributed to that group of policies, less (2) P% of premium. (For this purpose, risk based capital attributed is determined by calculating the total C-2 risk based capital with and without such policies, and taking their difference.)

For purposes of this section, the value of P is $(0.01 \times 0.5 \times [(500 + n)/n])$, where n is the number of insured lives. The result, expressed as a percentage of premium, is the remaining RBC allowed.

Credits generated by all of the adjustments described in this section for a particular policy cannot exceed the total RBC for that particular policy.

[DRAFTING NOTE: For reporting purposes, companies should be allowed to provide an actuarial certification of these specific calculations. This would apply where information required was either: i) detailed, ii) confidential, or iii) not available and estimated. In any of these situations, an actuary could certify that the work done is a fair representation of the position of that particular company with respect to the formula. Generally, a certification would include a statement that the technique u and

June 1996

produced a similar and more conservative result, and would include a description of the method used to verify the result, and a description of any estimation techniques. It is expected that most of the information in this section will need to be estimated.]

J. Reinsurance Assumed

[C-2 Principal Worksheet-Premiums, lines 1.4, 2.2, 3 through 9; Worksheet 1.4]

The RBC amount for reinsurance assumed is determined by application of the formulas above to the amounts assumed by the reinsurer, except that the managed care credit is limited to category 1 level. Reinsurance assumed may be combined with directly written business.

For non-proportional and YRT reinsurance: (185% of the assumed premium) x (the appropriate RBC factor).

[DRAFTING NOTE: By allowing the assumed and direct business to be combined, RBC minimums and small block factors will not be multiplied when a reinsurer aggregates small blocks. However any desire that the ceded RBC which is based on the risk ceded will match the assuming RBC will be lost.]

[DRAFTING NOTE: Suggest that the reinsurer be allowed to use the latest available value for the managed care credit and other factors from the ceding company, rather than a current factor. This is due to reinsurers being unable to obtain current year-end information on a timely basis and the use of past factors should be allowed.]

II. C-4 Calculations

A. Adjustment for Increased Risk

[RBC Growth Adjustment to C-4]

The C-4 risk based capital for this element is 50% of the growth in C-2 risk based capital from the prior year in excess of 20%.

This calculation should be made separately with respect to each type of business as outlined in the RBC Instructions.

When health organizations merge or otherwise acquire both the assets and liabilities of another health organization, the growth in C-2 RBC should be based on the growth in RBC of the combined organization restated for the prior period. The (restated) RBC for the prior period should be calculated as if the new organization had been combined in the earlier period.

B. Guarantee Fund Assessment Risk

To the extent there are potential assessments by a guarantee fund, the corresponding risk based capital is a function of the capital levels of other health plans in the service or license area. The risk based capital from this source is the product of (1) the total capital shortfall in the state (i.e., the dollar amount by which insurers are not meeting 200% of the Authorized Control Level), divided by the total health premium in the state, multiplied by (2) the company's health premium. In calculating the shortfall, only the proportion which would be assessable to health insurers should be counted.

To the extent the assessments are offset by premium taxes in the state, this risk factor should be offset.

[DRAFTING NOTE: The Life and Casualty Risk Based Capital formulas do not currently recognize this risk. It may be appropriate for those coverages, as well as health. Note also that this risk factor assumes that the Commissioner's office will provide a value each year for use in this formula, based on the relative financial health of the insurers operating in that jurisdiction. This calculation could be done as follows:

Each geographic jurisdiction must establish a risk factor that reflects the relative solvency risk of the competitors in that area. The factor represents the capital shortfall of all competitors in the area. It will be determined as follows:

THP = total health premium for the area

- TP = total premium for an area
- TC = total capital for all competitors in the area
- AC = total authorized control capital levels for all competitors in the area

The greater of {(THP/TP) x (2AC-TC)/THP} or 0.]

III. Modification to Basis of Reporting

A. Guarantees from Affiliated Companies

Where the contracts providing such guarantees made by other regulated insurance carriers or health plans, where the company has an unencumbered call on the assets of such other entities in the case of imminent insolvency, reporting for risk-based capital purposes can be made on a consolidated basis including all such carriers, at the insurer's option.

In other cases, recognition in this formula of such guarantees shall be made on a case-by-case basis, and only with the approval of the Commissioner in the state of domicile.

[DRAFTING NOTE: The Task Force's reasoning behind this section of the formula stemmed from the full guarantees extended between HMOs that are part of other organizations. The Task Force felt that some recognition of these guarantees was warranted. This is an attempt to address current practices but is not necessarily intended to encourage new affiliate guarantees.]

B. Investments in Subsidiary Health Carriers

The RBC for subsidiary health carriers should be accumulated into the parental entity through separately accumulating the C-1, C-2, C-3, and C-4 risks prior to the application of the covariance formula. Appropriate adjustments should be made to reflect percentage ownership and to eliminate any threshold amounts in the component charges which would otherwise be double-counted. After combining the risks of the parental entity and subsidiary entities, the covariance formula should then be applied.

In those cases where accounting practices would require the reporting of premium equivalents for the same business in both a subsidiary and parent company, adjustments should be made to ensure that the corresponding RBC amounts should be held only in the company which is directly providing the insurance guarantee or services.



APPENDIX 5

RBC Summary

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RBC Summary







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HEALTH ORGANIZATION RISK-BASED CAPITAL C-2 PRINCIPAL WORKSHEET - PREMIUMS

(a)	(6)	(c)	(d) Non-Propertional @ Premium	(e)	(f) Net		(g)			(b)	
Line	Coverage Description	Direct	Ceded	Assumed	(c)-(d)+(e)		RBC Factors	-	<u>RV</u> *	RBC Value	Line
1.	MEDICAL EXPENSE REIM.						Mgd Care Credit	LR			
1. 1.	1 Deductibles ≤ 2600 2 Deductible > 2500					. (f)× (f)×	1.00 x 1.00 x 1.67 x 1.00	-	1.00 1.00		1 .1 1.2
1. 1.	3 Non-Proportional Reins Ceded 4 Non-Proportional Reins, Ass.		*	-		(f)x (f)x	1.00 x 1.00 1.00		1.00 1.00		1.3 1.4
1. 1.	5 Stop-Loss Direct Less Ceded 8 Sub-Tolais					(f)×	1.00 x 1.00	· · · ·	1.00		1.5 1.6
2. 2.	DENTAL ONLY EXPENSE REIM. 1 Direct					(c)x	0.76 × - ×	-	1.0D [.]	.	2.1
2.	2 Non Proportional Reinsurance Assumed		-			(e)x	0.78	*	1.00		2.2
3.	MEDICARE SUPPLEMENT					(c)+1.85x(e-d))x	0.68 x 1.00 x		1.00	<u>_</u>	3.
4.	ACCIDENT ONLY 1 All Benefit Periods, Ail Reinsurance					(f)×	0,60 on first \$10 million + 0,25 on excess	1.00	1.00		4. 4.1
4 4	2 Nonproportional (including YRT) reinsurance included in line 4.1 3 Sub-Totals					.85x(e-d)		1.00	1.00		4.2 4.3
5.	HOSPITAL/I.C.INDEMNITY & SPECIFIED DISEASE		<u> </u>		<u> </u>	_ [(c)+1.85x(e-d)]	× 0.354		1,00	<u> </u>	5.
6. 6. 6.	CREDIT DISABILITY 1 Unearned Prem. Res. 2 Single Premium					(f)5* [(c)+1.85x(e-d)]	.6.2(f) =x x 1.26	-0.05	1.00 1.00		6.1 6.2
6	3 Other Premiums 4 Sub-Total					_ [(c)+1.85x(e-d)]	× 1.26		1.00		6.3 6.4



× 1

HEALTH ORGANIZATION RISK-BASED CAPITAL C-2 PRINCIPAL WORKSHEET - PREMIUMS

Γ	a)	(b)	(c)	(d) Non-Proportional	(0)	(f) Nat	(g)		····			(h)	
L	іле	<u>Coverage Description</u>	Direct	<u>Caded</u>	Assumed	(<u>c)-(d)+(e)</u>		RBC Facto	C\$			RBC Value	Line
7.		DISABILITY INCOME *											7.
	7.1	All Benefit Periods, All Reinsurance	.			·	(f)	0.25 on first \$ 0.1 on exces	12.5 million + Is	<u> </u>	1.00	<u> </u>	7.1
1	7.11	Nonproportional (including YRT)					.85*(e-d)×		-	1.00	1.00		7.11
	7.2	Credit for Benefit Periods of 24 months or less					(f)	Χ	-0.025		1.00	<u> </u>	7.2
 	7.21	Nonproportional (including YRT)		•		•	.85*(e-d)x	x	-0.025		1.00		7.21
	7.3	RBC Sub-Total						RB	C Sub-Total	l is 7.1+7.1	1+7.2+7.2	<u> </u>	7.3
B.		LONG-TERM CARE *											ŀ
	8.1	All Benefit Periods, All Reinsurance					(1)	0.25 on first \$	25 milion + 8	1.000	1.00		8.1
1	8.11	Nonproportional (including YRT)				•	.85*(a- d)x		-	1.000	1.00	= =	8.11
	8.2	Credit for Benefit Periods of 24 months or less		<u> </u>			Ø	x	-0.025		1.00		8.2
	8.21	Nonproportional (including YRT)					.85*(e-d)x	x	-0.025		1.00		7.21
	8.3	RBC Sub-Total										<u>.</u>	8.3
9.		OTHER HEALTH COVERAGE				-			<u>ن</u> خ				
	9.1 9.2	Intiationary Non-Inflationary					c)+1.85x(e-d)} [c]+1.85x(e-d)]	x x	1.5 1.25		1.00 1.00		9.1 9.2
	9.25	Non Medical Stop Loss				<u> </u>	c)+1.85x(e-d)]	x	1.00		1.00		9.25
	9.3 9.4	Administrative Service Contracts Sub-Total		**************************************	inis na marana			x	0.056		1,08		9.3 9.4



HEALTH ORGANIZATION RISK-BASED CAPITAL C-2 PRINCIPAL WORKSHEET - PREMIUMS

(a)	(b)	{c}	(d)	{9}	(1)	(9)		(b)	Ì
Line	Coverage Description		Premium		Net	RBC Factors	RV*	RBC Vatue	Line
10.	CEDED QUOTA SHARE OR OTHER PROPORTIONAL	<u>Direct</u>	<u>Ceded</u>	<u>Assumed</u>	(<u>c)-(d)+(e)</u>	(d)× <u>1.00</u>	1.00	<u> </u>	10.
11.	ASSUMED QUOTA SHARE OR OTHER PROPORTIONAL REINSURANCE					(e)x <u>1.00</u>	1.00	-	11.
12.	GRAND TOTALS PREMIUM: (1.8 + 2.1 + 2.2 + 3 + 4.1 + 5 + 6.2 + 6.3 + 7.1 + 8.1 + 9.4 + 10 + 11)	.			•···	(1.6 + 2.1 + 2.2 + 12.1 + 6.3 + 7.3 + 8.3	• 3 + 4.3 + 5 + 6.2 3 + 9.4 + 10 + 11)		12.1
8			Orace Check In	Pehodulo Li		FIXED AMOUNT RBC			12.2
12.2			Cross Crieck to Part A	Part 4	Part 1	12.3 Dental			12.3
12.3	\$ 		Line 62	Line A2	Line 2	12.4 Medicare Supplement			12.4
12.7			Cal 1	Col 1	Col 1	12.5 Accident Only			12.5
12.6	; ;					12.6 Hospital.I.C. Indemnity Or Specified Disease			- 12.6
137	2		12.7	Disability Income	e Minimum:non-nej	gative value of	- line7.3(h)	.	12.7
12.75	5		12.75	Long Term Care	Minimum:non-neg	alive value of	- line8.3(h)		12.75
12.77	?		12.77	Credit Disability	Minimum:adjustme	mi if 6.4(h)/6.4(f)<0.8		-	12.77
12.8	3 12.8	Adjustment For	Multiple Values:		75x[sum of 12.2	to 12.6-largest of lines 12.2 to 12.6]			12.8
12.5	9			Total Health P Based RBC	remium -	(12.1 + 12.2 + 12.3 + 12.4 + 12.5+12.6+12.7+12.75+12.77+12.8)			12.9
1	"Not Subject to RV adjustment			*RV fixed by NAIC	2				
	@ Exceptions are lines 4.1, 7.1 & 8	1. These are to	include proportion	nal reinsurance.					

WS1.1

Worksheet 1.1

Medical Expense Reimbursement Direct and Ceded Business

"Factor Credits" (column f) in the following table are to be applied to the corresponding "\$\$ paid" (column e) by category of care.

	(a)	(b)	(c)	(d)
	Category of Managed Care	\$\$ Paid	Factor Credit	Product
1	Category 1		15.0%	-
2	Category 2 Factor credit = 5.56 x (withholds + bonuses) / paid claims, (max: 25%)			-
3	Category 3		40.0%	-
4	Category 4		50.0%	-
5	None of the above (remaining claims not included in one of the categories above)		0.0%	-
6	Total	-		-
7	Total Managed Care Credit: 6(d) divided by 6(b). (Apply to the underlying C-2 RBC amount.)		0.0%	

To Col(g) Line 1.1, 1.2, 1.3, 1.5

A factor determined by the formula described in column (a).

Loss Ratio for Medical Expense Reimbursement

- 8.1 Claims [Line 6(b) above]
- 8.2 Less Medicare Supplement Claims included above
- 8.3 Net Claims for Medical
- 8.4 Premium Earned [Line 1.6(c)]
- 8.5 Loss Ratio [8.3) / 8.4)]

--0.0% To col(g) Line 1.1



Worksheet 1.3

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Medical Expense Reimbursement Non-Proportional Reinsurance Ceded

(a)	(b)	(c)	(d)	(e)	(f)	(g)
Reins	Res. Credit	Attachment	Recovery for Excess	Premium	RBC	RBC for
Acct #	Allowed	Point Less Than	Claims	Ceded	Factor	Account
	(%)	100K (Y/N)	(% of expected = ASL)			(b)x(e)x(f)
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
					1.000	-
Total				-		-
	2 m)(e) 310% 11	C(0) × 1/67				
	e estrates tops. It	1652.274		T () ()		
[e + (o)⊵≷5+ 0 0)(0]0)0)	⊰ oo((i))≤i≦10%a. -	51810 > 24 743	Average RBC Eactor	<u>Total (g)</u>	=	1.00
COI(C) S\$100,000		u ox lu		rotar (e)		1.00



Worksheet 1.3

Adjustment and/or Rate Approval Adjustment

[Include only if Reinsurer's premiums subject to change only

when Direct premiums change]

(h)	(i)	(j)	(k)	(1)	(m)	(n)	(0)	(p)	(q)		
	Ceded		Rate Guarante	e Period			Rate Approval				
Reins	Premium	Percent of				Percent of	Rate				
Acct #	(from	column (i)	Rate			column (i)	Approval				
	above)	with rate	Guarantee	RBC	Additional	subject to	Туре	RBC	Additional		
		guarantee	(in months)	Factor	RBC	rate approval	(1 or 2)*	Factor	RBC		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000				0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	_			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
-	-			1.000	-			0.184	-		
Total	-				-				-		

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encire remember elle web international provident for the 1922

2 All other approvals 184

Page 7



Worksheet 1.4

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Medical Expense Reimbursement Non-Proportional Reinsurance Assumed

(a)	(b)	(c)	(d)	(e)	(f)	(g)
Reins	Managed Care	Attachment	Recovery for	Premium	RBC	RBC for
Acct #	Factor from	Point	Excess Claims	Assumed	Factor	Account
	Ceded Co.	Less Than	(% of expected			(e)x(f)x(1-b)
		100K (Y/N)	= ASL)			
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
					1.00	-
Total				-		-
e-1(()) <112(0,()(0))	5 m (c) 21 (c) 2 m 3	et ex light				
Sa(0) Si (0) (0)	4.46(6)2461023.(11)	15332743				
CO((G):53100)(00(0)	1 FO (0) Kal 1 (0) Sa 1 (0)	10 . 27 (3	Average	Total (g)		4.00
(CO)(C) (C) (C)		45.201 67	RBC Factor	lotal (e)	=	1.00







Assumed Premiums with Additional RBC for Rate Guarantee Adjustment and/or Rate Approval Adjustment

(h)	(i)	(j)	(k)	(I)	(m)	(n)	(0)	(p)	(q)	(r)	(s)	(t)
	Ceded			R	ate Guarantee Per	riod				Rate App	oroval	
Reins	Premium	Percent of			Percent of				Percent of			
Acct #	(from	column (i)	Ceded		column (i)	Assumed			column (i)	Rate		
	above)	with ceding	Rate	Ceded	with assuming	Rate	Assumed		subject to	Approval		
		co. rate	Guarantee	RBC	co. rate	Guarantee	RBC	Additional	rate	Туре	RBC	Additional
		guarantee	(in months)	Factor	guarantee	(in months)	Factor	RBC	approval	(1 or 2)*	Factor	RBC
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
-	-			1.000			1.000	-			0.184	-
Total	-							-				-
য় হৈ ব্যালালন শ্বানাল/মন্নন্ন্ন	ica: 1910 SB month 1970 - SB months 2011 Yest	1. 251 1. (776) 1. (776)										
	CALCHER HERE	Inconcerca de la conforte	- Contraction and a	al hore								

Medical Expense Reimbursement Stop-Loss Coverage

a. Specific Stop-Loss Only

		(a)		(b)		(c)
	Attachment Point	Premium		RBC Factor		Base RBC
i	Attachment Point < 100K		x	1.67	=	-
ii	Attachment Point ≥ 100K		x	2.78	=	•

b. Aggregate Stop-Loss or Specific/Aggregate Combinations

1. Group Size Under 50 Employees and/or Aggregate Stop-loss Attachment Point <110%

	(a)		(b)		(c)
Attachment Point	Premium		RBC Factor		Base RBC
Specific Attachment Point < 100K		x	2.505	=	-
Specific Attachment Point ≥ 100K		x	4.17	-	
No Specific		x	4.17	=	

2. Group Size 50+, Aggregate Stop-Loss Attachment Point 110% or Greater

	(a)		(b)		(c)
Attachment Point	Premium		RBC Factor		Base RBC
Specific Attachment Point < 100K		x	1.7953	=	-
Specific Attachment Point ≥ 100K		x	2.9885	=	
No Specific		x	2.9885	=	-

c. Totals

i

	(a)	(b)	(c)
	Premium	Average Factor	Base RBC
Totals For Line 1.5	-	1.0000	



i

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WS2.1

Worksheet 2.1

Dental Expense Reimbursement Direct Business

"Factor Credits" (column f) in the following table are to be applied to the corresponding "\$\$ paid" (column e) by category of care.

	(a)	(b)	(C)	(d)
	Category of Managed Care	\$\$ Paid	Factor Credit	Product
1	Category 1		15.0%	-
2	Category 2 Factor credit = 5.56 x (withholds + bonuses) / paid claims, (max: 25%)			-
3	Category 3		40.0%	-
4	Category 4		50.0%	-
5	None of the above (remaining claims not included in one of the categories above)		0.0%	-
6	Total	-		-
7	Total Managed Care Credit: 6(d) divided by 6(b). (Apply to the underlying C-2 RBC amount.)		0.0%	

To col(g) line 2.1

A factor determined by the formula described in column (a).

Loss Ratio for Dental Expense Reimbursement

Г		
8	3.1 Claims [Line 6(b) above]	
8	3.2 Premium Earned [Line 2.1(c)]	-
8	1.3 Loss Ratio [8.1) / 8.2)]	0.0%
		To col(g) Line 2.1
ł		



Worksheet 9.25

Non-Medical Expense Reimbursement Stop-Loss Coverage

a. Specific Stop-Loss Only

Γ		(a)		(b)		(c)		
	Attachment Point	Premium	RBC Factor			Base RBC		
	<\$100K or <2years		X	1.11	=			
i F	≥\$100K or ≥2years		X	1.85	=	-		

i

ii

iii

b. Aggregate Stop-Loss or Specific/Aggregate Combinations

1. Group Size Under 50 Employees and/or Aggregate Stop-loss Attachment Point <110%

	(a)		(b)		(c)		
Attachment Point	Premium		RBC Factor		Base RBC		
Specific Attachment <100K or < 2 years		x	1.665	=			
Specific Attachment ≥100K or ≥ 2 years		x	2.775	=			
No Specific Stop-loss Coverage		X	2.775	=	-		

2. Group Size 50+, Aggregate Stop-Loss Attachment Point 110% or Greater

	(a)	T	(b)		(c)
Attachment Point	Premium		RBC Factor		Base RBC
Specific Attachment <100K or < 2 years		x	1.19325	=	-
Specific Attachment \geq 100K or \geq 2 years		x	1.98875	=	-
No Specific		X	1.98875	=	-

c. Totals

I

	(a)	(b)	(c)
	Premium	Average Factor	Base RBC
Totals For Line 9.25	-	1.0000	-







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CEDED: QUOTA SHARE & PROPORTIONAL REINSURANCE

(All Health Lines of Business)

		(a)	(b)	(c)	(d)	(e)	()
		Reinsurance Acct	Direct Premium	Ceded Premium	Proportion of Risk Ceded	Direct RBC	Ceded RBC
a.	Medical Expense Reimbursement Reins. 1					<u> </u>	
						· _	
b.	Dental Expense Reimbursement Reins, 1					-	. 4
С.	Medicare Supplement Reinsurance 1						
							
d.	Accident Only 2	XXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX
		XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXXX
		XXXXXXX		XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX
ê.	Hospital Indemnity/ Specified Disease						· · · · · · · · · · · · · · · · · · ·
					·	••• •••	
f.	Credit Disability	1755 1978 (mails are also a					
	Single Premium w/ Reserves Ceded						
	Single Premium w/ Reserves Retained 3						
				<u> </u>		<u> </u>	
1	1		I	1	1	-	<u> </u>

		(a)	(b)	(c)	(d)	(e)	
		Reinsurance	Direct	Ceded	Proportion of	Direct RBC	Ceded RBC
		Acet	Premium	Premium	Risk		
					Ceded		
<u></u>	Other Credit Disability						
						· · · · · · · · · · · · · · · · · · ·	-
						· •	-
g.	Disability Income 4	XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX
		XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXXXX
		XXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX
h.	Long Term Care 5	XXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX
		XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX
		XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX
i	Other Health Coverage					······	-
						-	
	TOTALS						÷
			c	77		Coded RBC	
			_	to line 10(d)		(en	ter as negativ
			AVER/	AGE FACTOR:	1.00		
					to line 10(g)		

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Use aggregate loss ratio and managed care factor.
Ceded premium is assumed to be in excess of \$10 million.

3 Calculate without credit for reserves retained on reinsurance.

4 Companies may calculate the ratio of ceded claim reserves from quota-share or proportional reinsurance agreements to direct claim reserves where the ceded premium base is not consistent with the direct premium base (e.g. ceded on YRT while direct is level premium). This ratio times direct premium times direct RBC factor would produce the ceded RBC.

5 Ceded premium is assumed to be in excess of \$25 million.

WS10





Ceded Premiums with Additional RBC for Rate Guarantee Adjustment and/or Rate Approval Adjustment

[Include only if Reinsurer's premiums subject to change only

when Direct premiums change]

(h)	(i)	(j)	(k)	(1)	(m)	(n)	(0)	(p)	(q)
	Ceded		Rate Guara	ntee Period			Rate Approv	val	
Reins	Premium	Percent of				Percent of	Rate		
Acct #	(from	column (i)	Rate			column (i)	Approval		
	above)	with rate	Guarantee	RBC	Additional	subject to	Туре	RBC	Additional
		guarantee	(in months)	Factor	RBC	rate approval	(1 or 2)*	Factor	RBC
0	-			1.000	-			0.184	-
0	*			1.000	-			0.184	-
0	-			1.000	-			0.184	-
0	-			1.000	-			0.184	-
0	-			1.000	-			0.184	-
0	-			1.000	-			0.184	-
				1.000	-			0.184	-
				1.000	-			0.184	-
				1.000	-			0.184	-
				1.000	-			0.184	-
		· · · · · · · · · · · · · · · · · · ·		1.000	-			0.184	-
Total	-				-				-
Rale Guarante	9 09)			an an an Araba an Araba An Araba an Araba an Araba An Araba an Araba an Araba					

15 to 36 months: .251

Over 36 months : .673



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Worksheet 11

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1

(All Health Lines of Business)

ASSUMED: QUOTA SHARE & PROPORTIONAL REINSURANCE

		(2)	(b)	(c)	(d)	(e)	()	(9)	(h)
		Reinsurance	Assumed		Information	Reported from D	rect Writer		
		Acct	Premium	Olrect	Ceded	Proportional	Caded	MCCF	Assumed
1				Premium	Premium	Reinsurance	RBC		RBC
	Medical Expense								•
<u>a</u> .	Reimbursement Reins.							0,10	-
			•						•
									-
Ь.	Dental Expense								
	Rembursement Keins.					<u> </u>		<u> </u>	
						<u> </u>	·		÷
				<u> </u>		 			• ·
e.	Redicare Supplement							0.10	_
	Realsulance I		t			<u> </u>		4.14	
				}		 			
	Accident Only 2			VYYYYYY	******	YYYYYY	YYYYYY	YXXXXXX	XXXXXXX
<u>u.</u>		~~~~~		VVVVVVV	******	VYYYYYY	YYYYYY	YYYYYYY	XXXXXXXX
		XXXXXXX	~~~~~	VVVVVV	~~~~~		XXXXXXXX	YYYYYYY	XXXXXXXX
 	Hospital Indomnitud				~~~~~			******	
e.	Specified Disease							0.10	-
 									· · · ·
	-					-			
f	Credit Disability								
ļ''	Sinola Premium								
	w/ Reserves Ceded 3							0.10	
	·	1				1			· · · · · · · · · · · · · · · · · · ·
	}	<u> </u>		1	1	1	1		· · · · · · · · · · · · · · · · · · ·
	Single Premium	 		1				1	• • • • •
	w/ Reserves Retained 4						l	0.10	
									- ·
			1						

WSII

	1	[6]	(b)	(c)	(d)	(9)	(1)	(g)	(h)
		Reinsurance	Assumed		Information F	Reported from Di	rect Writer		
		Acct	Premium	Direct	Ceded	Proportional	Ceded	MCCF	Assumed
				Premium	Premlum	Reinsurance	RBC		RBC
	Other Credit Disability							· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·
									_
g.	Disability Income 5	XXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXXX
	1	XXXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXX	X000000X
	1	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXXXX	XXXXXXXX
h.	Long Term Care 6	XXXXXXXX	XXXXXXX	XXXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXX	XXXXXXXX	XXXXXXXX
		XXXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXXX
		XXXXXXXX	XXXXXXXXX	XXXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXXX
i.	Other Health Coverage								
						<u> </u>			
					· · · · · · · · · · · · · · · · · · ·				·····
	TOTALS		•	÷.	······································				· · · ·
	-		Assumed Premiu	un -					Assumed RBC
			to line 11(e)		A 1/2		4 00	1	ល ហេច 17(g/
					AVE	inmue frigi un.	to line 11(g)	-	

1 MCCF limited to category 1 for assuming company.

2 Assumed premium is applied at margin of direct-ceded.

3 Use Single Premium rules.

. .

4 Use Other Credit Disability rules.

5 Companies may calculate the ratio of ceded claim reserves from quota-share or proportional reinsurance agreements to direct claim reserves where the ceded premium base is not consistent with the direct premium base (e.g ceded on YRT while direct is level premium). This ratio times direct premium times direct RBC factor would produce the assumed RBC.

6 (assumed premium is applied at margin of direct-ceded.)



Assumed Premiums with Additional RBC for Rate Guarantee Adjustment and/or Rate Approval Adjustment

(h)	(1)	(i)	(k)	(1)	(m)	(n)	(0)	(p)	(q)	(r)	(8)	(t)
	Ceded			Ra	te Guarantee Peri	od				Rate Appro	val	
Reins	Premium	Percent of			Percent of							
Acct #	(from	column (i)	Ceded		column (i)	Assumed			Percent of			
	abovel	with ceding	Rate	Ceded	with assuming	Rate	Assumed		column (i)	Rate		
		co. rate	Guarantee	RBC	co. rate	Guarantee	RBC	Additional	subject to	Approval	RBC	Additional
		guarantee	(in months)	Factor	guarantee	(in months)	Factor	RBC	rate approval	Туре	Factor	RBC
0				1.000			1.000	-			0.184	-
0	-			1.000			1.000	-			0.184	-
0				1.000			1.000	-			0.184	-
0				1.000			1.000	-			0.184	-
0				1.000			1.000	-			0.184	· ·
				1.000			1.000	-			0.184	
				1.000			1.000	-			0.184	-
				1.000			1.000	-			0.184	-
				1.000			1.000	-			0.184	-
				1.000			1.000	-			0.184	-
				1.000			1.000	-			0.184	-
Total								-				-
e Guaran			non stiet is Nation Fait Constant and	el par seu								
	15 to 36 months: .251											

Over 38 months , 673 ovals:

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e Approvals. 1 Rata changes allowed up to pre-approved trand: 1.092

2 All other approvals: .184

Worksheet 11

Worksheet 11b

ASSUMPTIONS:

- 1. Info from Direct Writer would be latest available (not more than 12 months old).
- 2. Assumed Premium may not be consistent with Direct Premium (due to 1 above).
- 3. Formula for Assumed RBC: from assuming company from direct writer.

Assumed	Direct Premium	Proportional	Ceded RBC	{1 - cat 1 MCCFR}
Premium x	Ceded Premium x	Reinsurance x	ct Prem x Prop Rei	MCCF
= Direct Premium			Related Ceded REBC	;
			to Ceded Premium	
	<u> </u>			
This reduces to:		Asssumed	Ceded RBC	MC
		Premium x	Ceded Premium x	Adjustment
But should approx	cimate:			
Direct	Proportionate	[]×	(1 - cat 1) x	Loss Ratio
Premium x	Reinsurance x			

4. Credit Insurance - Assumed single premium with reserves retained is equivalent to "Other Credit".





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HEALTH ORGANIZATION RBC C-2 PRINCIPAL WORKSHEET - OTHER RISKS

(a) Line	(b) Risk Description	(c) Exposure Amount	(d) RBC Factor	BY	(e) RBC Value	(f) <u>Source</u>
0.1 a.	Assessments other than Guarantee Fund Assessment	ts				Worksheet O.1
0.2 a. b.	Rate Guarantee Adj NonCan Adjustment		{0.25} up to \$12.5 million	<u> 1.00 </u>	<u>-</u>	Worksheet 0.2a Schedule H-Part 1 Column 5 Line 2
c. d.	Performance Guarantee Rate Approval Adj.			1.00	<u> </u>	Worksheet 0.2c Worksheet 0.2d
0.3	ASC and Cost Plus Premium Equivalents	(From New Statement Line)	x 0.005	1.00		
0.4 a.	Claim Reserve-Credit Disability	<u> </u>	{0.1} up to \$7.5 million 1.000 + (.04) of excess	1.00		
þ.	Claim Reserve-Dis Income		(0. 1) up to \$35 million 1.000 + (.04) at excess - (.06) x STR x min (max (reserve - 15M,0),20M)	1.00		
C.	Claim Reserve-LTC	<u></u>	(0.1) up to \$15 million <u>1.000</u> + {.04} of excess	1.00	<u> </u>	
0.5	Credit for Rate Stabilization Reserves, Dividends and Retrospective Rate Adjustments			1.00	<u>-</u>	Worksheet 0.5
0.6	SUBTOTAL				<u> </u>	
0.7	Statement of Actuarial Opinio	n? (Y/N)	N			
	Valuation Variations	0.6(e) + 12.9(h) from premium w/s	x 0.20			OTHER HEALTH TOTAL C-2

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ASSESSMENTS OTHER THAN GUARANTEE FUND ASSESSMENTS
WORKSHEET 0.1

ſ	(a)	(b)
1	Current Year Assessment	
2	Prior Year Assessment	
3	Previous Prior Year Assessment	
4	Current Year Line 1.6 col(c) from Primary Worksheet-Premiums	-
5	Prior Year Line 1.6 col(c) from Primary Worksheet-Premiums	
6	Previous Prior Year Line 1.6 col(c) from Primary Worksheet-Premiums	
7	Current Year Assessment Ratio	
8	Prior Year Assessment Ratio	
9	Previous Prior Year Assessment Ratio	<u> </u>
10	(Greatest of Lines 7,8,or 9)	-
11	(Smallest of Lines 7,8,or 9)	-
12	Line 10 - Line 11	
13	Absolute Value of Line 12 x Line 4	

RATE GUARANTEE ADJUSTMENT

•

(a)	(b)	(c)	(d)
RGA	.1	PREMIUM SUB-TOTAL (1.6 + 2.1 + 3 + 9.1)	-
	.2	% with rate guarantee < 16 months or anniversary	
	.3	% with rate guarantee 16-36 months	
	.4	% with rate guarantee > 36 months	

ADDITIONAL RBC						
(a)	(b)	(c)				
a.	Direct RGA .1 x (RGA.3 x .251 + RGA.4 x .673)	-				
b.	Ceded - Quota Share/Proportional w/s 10					
C.	Ceded - Non-Proportional - w/s 1.3	-				
d.	Assumed - Quota Share/Proportional w/s 11	-				
е.	Assumed - Non-Proportional - w/s 1.4	-				
ΤΟΤΑ	L (a - b -c +d +e)	-				

PERFORMANCE GUARANTEE RBC

Part 1. Expense Margin Guarantees

(a)	(b)	(C)	(d)
Group ID	Description of Guarantee	Annualized Exposure	Additional RBC ¹
			-
			-
			-
			-
			-
		-	~

Part 2. Claim Trend Increase Limitation

(a)	(b)	(C)	(d)
Group ID	Description of Guarantee	Annualized Exposure	Additional RBC ¹
			-
			*
			-
			-
			-
		-	_

Part 3. Other

(a)	(b)	(c)	(d)
Group ID	Description of Guarantee	Annualized Exposure	Additional RBC ¹
			_
			-
			-
			-
		-	-

TOTAL

(a)	(b)	(C)	(d)
Group ID	Description of Guarantee	Annualized Exposure	Additional RBC ¹
1 Annualize	d Exposure * 0.3	-	



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RATE APPROVAL ADJUSTMENT

PR	E	М	IL	١N	l

	(a)	(b)	(c)	(d)
	Medicare Risk	Medicaid Risk	Other	Total
Rate changes up to pre-approved trend allowed				0
2 All other approvals				0
(<u></u>				0

	PERCENTAGE					
OPTIONAL	(a)	(b)	(C)	(d)		
	Medicare	Medicaid		Premium		
	Risk	Risk	Other	Total		
3 line (2) with approval with 45 days				0		
4 (line 2)-(line 3)	<u>i.</u>			0		
5 Sum				0		

ADDITIC	ONAL RBC:			
a.	Line 1col(d) x .092 + Line 2col(d) x .184	Ő		
b.	.092x(Line 1col(d)-Line 3col(d))+.46x(Line 4col(d))			
b5.	Lesser of (Line a or b) x [1-mgd care fctr(w1.1)]			
C.	Ceded - Quota Share/Proportional w/s 10	0		
d.	Ceded - Non-Proportional - w/s 1.3	0		
ē.	Assumed - Quota Share/Proportional w/s 11	0		
f.	Assumed - Non-Proportional - w/s 1.4	0		
TOTAL	b5 + (e + f - c - d)	0		







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CREDITS FOR RATE STABILIZATION RESERVES DIVIDENDS AND RETROSPECTIVE RATE ADJUSTMENTS

(a)	(b)	(c)	(d)	(9)	(f)	(g)	<u>(h)</u>	(i)	<u> </u>
Group	Type of	Direct	Allocated	RSR, Div,	Ceded	Ceded	Number	Value	RBC
Identifier	Health	Premium	Direct	OR Retro	Premium	RBC	of Lives	of 'P'	Offset
	Insurance		RBC	Amount		(2)	(3)	(4)	(5)
			(1)						
						-		0.01	-
						-		0.01	-
						-		0.01	-
						-		0.01	-
						-		0.01	-
						-		0.01	-
						-		0.01	-
· · · · · · · · · · · · · · · · · · ·						-		0.01	-
						-		0.01	-
						-		0.01	-
						-	_	0.01	-
	· · · · · ·					-		0.01	-
						-		0.01	-
						-		0.01	
			_			-		0.01	-
						-		0.01	-
						-		0.01	-
(1)	For type of bus	siness use ratio	from C-2 Princi	ipal w/s- Premiu	um col (h)/ col (f).			
(2)	(col(d) / col(c))	x 1.85 x ceded	premium for th	e group.					
(3) If details for Lives is not available, use number of certificates (I.e. no averages by family composition).									
(4)	(4) Greater of 1% or .01 x .5*{[500 + (h)]/(h)}.								
(5)	Lesser of (e) o	r [(d)-(i)x(c)-g].							
Show Subtotals: for RSR (should not exceed insert to line 11.2 on page 3).									
for DIVS (should not exceed line 10 col (2) schedule H-Part 1).									
		for RETROS (I	no cross check	available - actu	arial certificatio	n required).			
							(GRAND TOTAL	-



HEALTH ORGANIZATION RISK BASED CAPITAL

Principal Worksheet - C-4 RBC Growth Adjustment to C-4

(a)	(b)	(c)	(d)	(e)	(1)	(g)
C-2 Principal		w/s 10	w/s 11	Net RBC	120% of Prior	Difference
Worksheet		Ceded RBC	Assumed RBC	(b) - (c) + (d)	Year	(e) - (f) > 0
Line	Col (h) Value	<u></u>			Net RBC	
1.6		_	-			-
2.1 + 2.2			-	-		
3	-	_	-	, 		
4	-	-	-			-
5		-				-
6.1 + 6.2 + 6.3	-	-	-	-		
7.3	-	-		-		
8.1 + 8.2	•					-
9.4	-	-	-	-		-

GRAND TOTAL x 0.5

Additional C-4 RBC -

HEALTH ORGANIZATION RISK-BASED CAPITAL C-2 PRINCIPAL WORKSHEET - PREMIUMS

General instructions:

The net earned premiums will be calculated automatically as column (c) - (d) + (e).

Column 'd' for lines 1 to 9 should include only non-proportional reinsurance ceded and column 'd' line 10 should include all proportional reinsurance ceded. Column 'e' for lines 1 to 9 should include only non-proportional reinsurance assumed and column 'e' line 10 should include all proportional reinsurance assumed.

Earned premiums should total to those reported in the annual statement. For any state that reports cost plus revenue as premium include cost plus revenue with ACS on line 9.3.

All credits to RBC are optional.

1. Medical Expense Reimbursement

Include data on policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage, Medicaid risk coverage and stop-loss, but excluding dental only, accident expense, specified disease coverage and hospital indemnity.

1.1 Deductibles ≤ 2500

Earned premiums for medical policies with annual deductibles for an individual less than or equal to \$2,500.

The managed care credit for worksheet 1.1 comes from that worksheet.

The loss ratio from worksheet 1.1 comes from that worksheet.

1.2 Deductibles > 2500

Earned premiums for medical policies with annual deductibles for an individual over \$2,500 should be entered. If individual deductibles are not specified, include premiums for policies with family deductibles over \$2,500. If the premium for individual coverage with deductibles over \$2,500 do not exceed 15% of premiums for all individual coverage, include these premiums in 1.1 Deductibles \leq \$2,500.

The managed care credit for worksheet 1.1 comes from that worksheet.

1.3 Non-proportional reinsurance ceded

Earned premiums ceded comes from the total of column 'E' in worksheet 1.3.

The RBC factor comes from worksheet 1.3.

The managed care credit comes from worksheet 1.1

1.4 Non-proportional reinsurance assumed

Earned premiums assumed comes from the total of column 'B' in worksheet 1.4.

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The RBC factor comes from worksheet 1.4.

The managed care credit comes from worksheet 1.4

1.5 Stop-loss direct less ceded

Direct less ceded earned premiums comes from Total Line 1 column 'A' in worksheet 1.5.

The RBC factor comes from Total Line 2 column 'B' in worksheet 1.5.

The managed care credit comes from worksheet 1.1

2. Dental Expense Reimbursement

Include data on 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.

2.1 Dental expense reimbursement

Enter earned premiums for dental policies.

Enter the managed care credit from worksheet 2.1.

The loss ratio from worksheet 2.1 comes from that worksheet.

2.2 Dental non-proportional reinsurance assumed

Enter premiums for non-proportional reinsurance assumed.

3. Medicare supplement

Enter earned premiums for Medicare supplement policies.

Enter the managed care credit from worksheet 1.1.

The loss ratio should be calculated using the earned premiums and incurred claims from the general interrogatory from Medicare Supplement.

4. Accident Only

Enter earned premiums for accident only policies.

5. Hospital and intensive care indemnity and specified disease

Earned premiums for policies providing for hospital and intensive care indemnity and for those which provide benefits specifically for cancer, dread disease and/or specified diseases.

6.1 Credit disability unearned premium reserve

Enter the unearned premium reserve for credit disability income coverage from Schedule H of the Life and P&C annual statement blank Part 2 Section A line 1 Column 3 or comparable amounts.

6.2 Single credit disability premium

05/01/96 8:35 PM

Enter earned premiums for single premium credit disability policies.

6.3 Other credit disability premium

Enter earned premiums for credit disability policies other than single premium policies. Include data on policy forms that provide Overhead Expense Benefits and Mortgage Disability Income Benefits.

7. Disability Income

Include data on policies providing monthly or weekly income benefits for disability arising from sickness and/or accident Include data on policy forms that provide Overhead Expense Benefits and Mortgage Disability Income Benefits. Policies providing limited benefits, for example, where benefits are payable only in the event of injury in a public conveyance, should be placed in "Accident Only".

7.1 Disability income earned premiums

Enter earned premiums for disability income policies.

7.2 Credit for short benefit period coverages.

Enter premiums for disability income policies with benefit periods of 24 months or less.

8. Long term care

Include data on all long term care insurance policies except for accelerated death benefit-type products.

8.1 Long term care earned premiums

Enter earned premiums for long term care policies.

8.2 Credit for short benefit period coverages.

Enter earned premiums for long term care policies with benefit periods of 24 months or less..

9. Other health coverage

These coverages include all health premiums not included above

9.1 Inflationary

Earned premiums for other coverages that are subject to the effect of medical inflation should be entered

9.2 Non-inflationary

Enter premiums for other coverages that are not subject to the effect of medical inflation.

9.25 Non-meidcal stop loss

Direct less ceded earned premiums comes from Total Line 1 column 'A' in worksheet 9.25.

The RBC factor comes from Total Line 2 column 'B' in worksheet 9.25.



9.3 ASC

Enter ASC premium from the ASC interrogatory.

10. Ceded quota share or other proportional reinsurance.

Enter total ceded quota share or other proportional reinsurance premiums from worksheet 10.

Enter the average RBC factor from worksheet 10.

11. Assumed quota share or other proportional reinsurance.

Enter total quota share or other proportional reinsurance premiums from worksheet 11.

Enter the average RBC factor from worksheet 11.

12.2 Medical expense reimbursement

Enter 2 times the maximum retained risk after reinsurance on any single life not to exceed \$1,500,000.

12.5 Accident Only

Enter 3 times the maximum retained risk after reinsurance on any single life.

12.7 Disability Income

Enter 3 times the maximum benefit amount retained per life over a benefit period not to exceed 100 months.

12.8 Long Term Care

Enter 3 times the maximum benefit amount retained per life over a benefit period not to exceed 100 months.
Managed Care Credits Worksheet 1.1 Instructions

General Instructions

Payments made under managed care arrangements which meet the following definitions are subject to a C-2 credit. Credit can be obtained under only one category per each dollar of payment. If payments are eligible under the definitions provided for more than one category of managed care credit, the company may choose the category to use for the calculation. In addition, there may be cases in which a risk-reducing payment arrangement has not been accounted for within the managed care categories. In such cases, a company will determine the appropriate category based on analogous treatment of the payment arrangements.

Payments are to be separated according to the category in which they belong as defined below. Additional definitions include: category of managed care; the managed care, risk-reducing payment type, \$\$ Paid; the dollar amount paid to providers, factor credit; the managed care credit percent applied to the dollar amount or claims paid, product; the result of the calculations which are described below.

Category 1 Definition

Category 1 is payments made at levels set by contractual agreements, as fixed fees. The levels set by contractual agreements are specified at the beginning of the contract and are good for at least one year. Category 1 includes the following sub-categories which represent the major risk-reducing payment types:

- Per Diems
- Physician Reimbursement Scheduled
- Case Rates
- DRG's

Category 2 Definition

Category 2 is claim payments made under contractual agreements with withholds. The credit can only be taken if the prior year's total paid withholds and bonuses divided by the total withholds is greater than 50%.

Category 3 Definition

Category 3 is capitation payments made to entities directly providing medical care, for care directly provided and capitation as a percentage of premium. If such payments are demonstrably less than 5% of the total capitation payments, the full credit can be taken. This category excludes capitations where retroactive adjustments in excess of 5% can be made to such capitations as a result of specific performance targets other than total corporate financial results of the health plan. Excludes capitations paid to an organization where any payments are made by that organizations to another corporate entity for provision of care, unless such payments are made by that organization to another corporate entity for provision of care, unless such payments can be explicitly identified, in which case they should be used to reduce the credit otherwise allowed in this item.

Category 4 Definition

Category 4 is non-contingent salaries or aggregate cost payments, when paid directly to persons licensed to provide medical care. It includes the portion of payments made to entities which is passed on to medical care personnel directly providing care, where all payments are non-contingent salaries. This category is for the highest level of control a plan may exercise over variation in health care costs due to price or volume. *[Examples to be included per task force approval]*

Instructions for the Chart on Worksheet 1.1

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Line 1, column (e)	Enter the amount paid that meets the above definition of Category 1 on line 1(e).
Line 1, column (g)	Enter the amount of line 1(e) multiplied by 15%.
Line 2, column (e)	Enter the amount paid that meets the above definition of Category 2 on line 2(e). This amount is the sum of the claims paid subject to withholds if the company meet the 50% criterion.
Line 2, column (g)	Enter the amount of line 2(e) multiplied by 25%.
Line 3, column (e)	Enter the amount paid that meets the above definition of Category 3 on line 3(e).
Line 3, column (g)	Enter the amount of line 3(e) multiplied by 40%.
Line 4, column (e)	Enter the amount paid that meets the above definition of Category 4 on line 4(e).
Line 4, column (g)	Enter the amount of line 4(e) multiplied by 50%.
Line 5, column (e)	Enter the remaining amount not included in one of the above categories.
Line 5, column (g)	Enter the amount of line 5(e) multiplied by 0%.
Line 6, column (e)	Enter the sum of line 1(e), 2(e), 3(e), 4(e), 5(e).
Line 6, column (g)	Enter the sum of line $1(g)$, $2(g)$, $3(g)$, $4(g)$, $5(g)$.
Line 7, column (f)	Enter the amount of line 6(g) divided by line 6(e). This is the total managed care credit percentage. Enter this amount on the Principal Worksheet line 1.1 column (g).

Instructions for the bottom portion of Worksheet 1.1; Loss Ratio for Medical Expense Reimbursement

[Line references used are from earlier worksheets and may need to be updated]

- Line a Enter the amount on line 6(e) above.
- Line b Enter the amount of Medicare Supplement Claims
- Line c Subtract line b from line a and enter amount
- Line d Enter Premium earned from line 1.7© of the Principal Worksheet
- Line e Enter the amount of line c + line d. This amount is the loss ratio. Enter this amount on the Principal Worksheet, line 1.1 column (g).

Worksheet 1.3

Instructions for the Top Portion of Worksheet 1.3

This is an optional worksheet designed to compute the average RBC credit for medical expense reimbursement non-proportional reinsurance ceded. Reinsurance agreements can have individual attachment points (Column c) or aggregate attachment points (Column d) or both.

- 1. Column a For each eligible reinsurance agreement, enter in column (a) the company's uniquely identifying number (or description) of the agreement.
- 2. Column b This is the indicator showing to the extent to which reinsurance is allowed as a credit. For reinsurance that receives no credit, the premium ceded is included in column e, with zero shown in columns f and g.
- Column c This indicates the attachment point of the reinsurance account with regard to any specific claim and is used to determine the RBC factor for the account. Attachment points under \$2,500 are included as non-proportional reinsurance and shown on this worksheet.
- 4. Column d This is the percent of aggregate expected claims which is the attachment point for the reinsurance.
- 5. Column e This is the amount of premium ceded on each reinsurance account. The total is carried forward to the principal worksheet, line 1.3, column d.
- 6. Column f This is the RBC factor for the reinsurance account. It is chosen from the table included in the gray shaded area based on the attachment points indicated in column c and d.
- 7. Column g This is the result of multiplying column e by column f by column b.
- 8. The Average RBC Factor This is calculated as the total of column g divided by total of column e. The result is carried forward to the principal worksheet, line 1.3, column g.

Instructions for the Bottom Portion of Worksheet 1.3

This portion is an optional worksheet designed to compute the RBC credit associated with the rate guarantee adjustment and the rate approval adjustment for non-proportional reinsurance ceded. The results of this worksheet are carried forward to Worksheet 0.2.a, line c and Worksheet 0.2.d, line d. This portion of Worksheet 1.3 should be included only if the reinsurers' premiums can be changed only when the direct premiums change. In other words, this portion of the worksheet should not be used if the reinsurer has the contractual right to change the premiums at any time other than when the direct premiums change.

- 1. Column h This is the company's uniquely identifying number for the reinsurance program from column (a), above, for which some premium is subject to rate guarantees or rate approval.
- 2. Column i This is the amount of premium ceded if any is subject to the rate guarantee adjustment or the rate approval adjustment. It should equal column c for the reinsurance agreement.
- 3. Column j This is the percent of the subject premium which is subject to a rate guarantee exceeding 15 months.
- 4. Column k This is the number of months of the rate guarantee.
- 5. Column 1 The factor from the gray area for the appropriate rate guarantee period.
- 6. Column m This is column i muliplied by column j muliplied by column l.
- 7. The total for column m is transferred to Worksheet 0.2.a, line c.
- 8. Column n [columns related to rate approval adjustment, for which instructions have not been completed]



Worksheet 1.4

Instructions for the Top Portion of Worksheet 1.4

This portion of the worksheet is designed to compute the average RBC factor for medical expense reimbursement non-proportional reinsurance assumed. The assuming company may use information from the ceding company as long as it is not over one year old.

- 1. Column a For each eligible reinsurance agreement, enter in column (a) the company's uniquely identifying number (or description) of the agreement.
- 2. Column b This is the average managed care factor for the company ceding this reinsurance subject to a limitation that it cannot exceed the Category 1 factor.
- 3. Column c This indicates the attachment point of the reinsurance account with regard to any specific claim and is used to determine the RBC factor for the account. Attachment points under \$2,500 are included as non-proportional reinsurance and shown on this worksheet.
- 4. Column d This is the percent of aggregate expected claims which is the attachment point for the reinsurance.
- 5. Column e Regardless of whether reinsurance credit is allowed to the ceding company, 100% of the assumed earned premium should be included in column c. The total is carried forward to the principal worksheet, line 1.4, column e.
- 6. Column f This is the RBC factor for the reinsurance account. It is chosen from the table included in the gray shaded area based on the attachment points indicated in column c and d.
- 7. Column g This is net RBC computation. It is equal to column e multiplied by column f multiplied by 1 minus the managed care factor shown in column b.
- 8. The Average RBC Factor This is calculated by dividing the total from column g by the total from column e. The result is carried forward to the principal worksheet, line 1.4, column g.

Instructions for the Bottom Portion of Worksheet 1.4

This portion of the worksheet is designed to compute the additional RBC associated with the rate guarantee adjustment and the rate approval adjustment for non-proportional reinsurance assumed. The results of this worksheet are carried forward to Worksheet 0.2.a, line c and Worksheet 0.2.d, line d. This portion of Worksheet 1.3 should be included when the reinsurers' premiums can be changed only when the direct premiums change or if the reinsurer's premium rates are guaranteed for more than 15 months.

- 1. Column h This is the company's uniquely identifying number for reinsurance program from column (a), above, for which some premium is subject to rate guarantees or rate approval.
- Column i This is the amount of premium assumed if any is subject to the rate guarantee adjustment or the rate approval adjustment. It should equal column e for the line.
- 3. Column j This is the percent of the subject premium which is subject to a rate guarantee exceeding 15 months as determined from the reinsured's records.
- 4. Column k This is the percent of the subject premium for which the reinsurer has guaranteed its premium rates to the reinsured for a period exceeding 15 months.
- 5. Column 1 This is the number of months of the rate guarantee.
- 6. Column m The factor from the gray area for the appropriate rate guarantee period.
- 7. Column n This is column i multiplied by the sum of column j plus column k, multiplied by column m.
- 8. The total for column n is transferred to Worksheet O.2.a, line c.
- 9. Column o [columns related to rate approval adjustment, for which instructions have not been completed.]



INSTRUCTIONS FOR WORKSHEET 1.5

This worksheet is for Aggregate and Specific coverages sold for medical benefits.

- Line a(i) Enter the premium in column (a) for Specific Stop Loss (SSL) coverages not sold in conjunction with Aggregate Stop Loss (ASL) Coverage and with attachment points less than \$100,000
- Line a(ii) Enter the premium in column (a) for Specific Stop Loss coverages not sold in conjunction with Aggregate Stop Loss Coverage and with attachment points greater than \$100,000
- Line b.1(1) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is less than \$100,000 and either the ASL attachment point is less than 110% or the coverage is sold to groups with fewer than 50 eligible employees
- Line b.1(ii) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is greater than \$100,000 and either the ASL attachment point is less than 110% or the coverage is sold to groups with fewer than 50 eligible employees
- Line b.1(iii) Enter the premiums in column (a) for Aggregate Stop Loss coverages sold without Specific Stop Loss Coverage and either the ASL attachment point is less than 130% or the coverage is sold to groups with fewer than 50 eligible employees
- Line b.2(i) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is less than \$100,000 and either the ASL attachment point is greater than 110% or the coverage is sold to groups with more than 50 eligible employees
- Line b.2(11) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is greater than \$100,000 and either the ASL attachment point is greater than 110% or the coverage is sold to groups with more than 50 eligible employees
- Line b.2(iii) Enter the premiums in column (a) for Aggregate Stop Loss coverages sold without Specific Stop Loss Coverage and either the ASL attachment point is greater than 110% or the coverage is sold to groups with more than 50 eligible employees
- Line c(i) Sum all lines of Column (a) and Column (c)
- Line c(ii) Divide Line c(i)col(c) by Linec(ii)col(a)

Managed Care Credits Dental Only Worksheet 2.1 Instructions

General Instructions

Payments made under managed care arrangements which meet the following definitions are subject to a C-2 credit. Credit can be obtained under only one category per each dollar of payment. If payments are eligible under the definitions provided for more than one category of managed care credit, the company may choose the category to use for the calculation. In addition, there may be cases in which a risk-reducing payment arrangement has not been accounted for within the managed care categories. In such cases, a company will determine the appropriate category based on analogous treatment of the payment arrangements.

Payments are to be separated according to the category in which they belong as defined below. Additional definitions include: category of managed care; the managed care, risk-reducing payment type, \$\$ Paid; the dollar amount paid to providers, factor credit; the managed care credit percent applied to the dollar amount or claims paid, product; the result of the calculations which are described below.

Category 1 Definition

Category 1 is payments made at levels set by contractual agreements, as fixed fees. The levels set by contractual agreements are specified at the beginning of the contract and are good for at least one year. It includes discount fee-for-service.

Category 2 Definition

Category 2 is claim payments made under contractual agreements with withholds. The credit can only be taken if the prior year's total paid withholds and bonuses divided by the total withholds is greater than 50%.

Category 3 Definition

Category 3 is capitation payments made to entities directly providing dental care, for care directly provided and capitation as a percentage of premium. If such payments are demonstrably less than 5% of the total capitation payments, the full credit can be taken. This category excludes capitations where retroactive adjustments in excess of 5% can be made to such capitations as a result of specific performance targets other than total corporate financial results of the health plan. Excludes capitations paid to an organization where any payments are made by that organizations to another corporate entity for provision of care, unless such payments are made by that organization to another corporate entity for provision of care, unless such payments can be explicitly identified, in which case they should be used to reduce the credit otherwise allowed in this item.

Category 4 Definition

Category 4 is non-contingent salaries or aggregate cost payments, when paid directly to persons licensed to provide dental care. It includes the portion of payments made to entities which is passed on to dental care personnel directly providing care, where all payments are non-contingent salaries. This category is for the highest level of control a plan may exercise over variation in health care costs due to price or volume.



Instructions for the Chart on Worksheet 2.1

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Line 1, column (e)	Enter the amount paid that meets the above definition of Category 1 on line 1(e).					
Line 1, column (g)	Enter the amount of line 1(e) multiplied by 15%.					
Line 2, column (e)	Enter the amount paid that meets the above definition of Category 2 on line 2(e). This amount is the sum of the claims paid subject to withholds if the company meet the 50% criterion.					
Line 2, column (g)	Enter the amount of line 2(e) multiplied by 25%.					
Line 3, column (e)	Enter the amount paid that meets the above definition of Category 3 on line 3(e).					
Line 3, column (g)	Enter the amount of line 3(e) multiplied by 40%.					
Line 4, column (e)	Enter the amount paid that meets the above definition of Category 4 on line 4(e).					
Line 4, column (g)	Enter the amount of line 4(e) multiplied by 50%.					
Line 5, column (e)	Enter the remaining amount not included in one of the above categories.					
Line 5, column (g)	Enter the amount of line 5(e) multiplied by 0%.					
Line 6, column (e)	Enter the sum of line 1(e), 2(e), 3(e), 4(e), 5(e).					
Line 6, column (g)	Enter the sum of line $1(g)$, $2(g)$, $3(g)$, $4(g)$, $5(g)$.					
Line 7, column (f)	Enter the amount of line 6(g) divided by line 6(e). This is the total managed care credit percentage. Enter this amount on the Principal Worksheet line 2.1 column (g).					

Instructions for the bottom portion of Worksheet 2.1; Loss Ratio for Dental Expense Reimbursement

[Line references used are from earlier worksheets and may need to be updated]

- Line a Enter the amount on line 6(e) above.
- Line b Enter the amount of Medicare Supplement Claims
- Line c Subtract line b from line a and enter amount
- Line d Enter Premium earned from line 2.7 column c of the Principal Worksheet
- Line e Enter the amount of line c ÷ line d. This amount is the loss ratio. Enter this amount on the Principal Worksheet, line 2.1 column (g).

INSTRUCTIONS FOR WORKSHEET 9.25

This worksheet is for Aggregate and Specific coverages sold for benefits other than medical.

- Line a(1) Enter the premium in column (a) for Specific Stop Loss (SSL) coverages not sold in conjunction with Aggregate Stop Loss (ASL) Coverage and with attachment points less than \$100,000 or 2 years
- Line a(ii) Enter the premium in column (a) for Specific Stop Loss coverages not sold in conjunction with Aggregate Stop Loss Coverage and with attachment points greater than \$100,000 or 2 years
- Line b.1(i) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is less than \$100,000 or 2 years and either the ASL attachment point is less than 110% or the coverage is sold to groups with fewer than 50 eligible employees
- Line b.1(ii) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is greater than \$100,000 or two years and either the ASL attachment point is less than 110% or the coverage is sold to groups with fewer than 50 eligible employees
- Line b.1(ili) Enter the premiums in column (a) for Aggregate Stop Loss coverages sold without Specific Stop Loss Coverage and either the ASL attachment point is less than 110% or the coverage is sold to groups with fewer than 50 eligible employees
- Line b.2(i) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is less than \$100,000 and either the ASL attachment point is greater than 110% or the coverage is sold to groups with more than 50 eligible employees
- Line b.2(ii) Enter the ASL and SSL premiums in column (a) for Aggregate Stop Loss coverages sold in conjunction with Specific Stop Loss Coverage where the SSL attachment point is greater than \$100,000 and either the ASL attachment point is greater than 110% or the coverage is sold to groups with more than 50 eligible employees
- Line b.2(iii) Enter the premiums in column (a) for Aggregate Stop Loss coverages sold without Specific Stop Loss Coverage and either the ASL attachment point is greater than 110% or the coverage is sold to groups with more than 50 eligible employees
- Line c(i) Sum all lines of Column (a) and Column (c)
- Line c(ii) Divide Line c(i)col(c) by Linec(ii)col(a)

Instructions for HORBC Worksheet 10

Purpose of this Worksheet:

To calculate the HORBC C-2 factor to be applied to reinsurance premiums ceded under quota share and other proportional reinsurance agreements.

"Proportional reinsurance" as used in these HORBC Worksheets means reinsurance where the reinsurer's share of any given loss is a constant proportion of the direct writer's loss. The most obvious example of proportional reinsurance is quota share or coinsurance in which the reinsurance premiums and losses are a constant proportion of the direct premiums and losses. The reinsurance premiums themselves, however, need not necessarily be proportionate to the direct premium; for example: on reinsurance of the excess of a monthly income benefit retention on disability policies, in modified coinsurance, or where the reinsurance premium is attained-age-based (e.g., YRT) while the direct premium is issue-age-based.

Also include on this Worksheet 10 any nonproportional ceded reinsurance agreements not reported elsewhere in the HORBC calculation.

[Note: while the instructions below generally refer to "direct" premium, that term is intended to include for the purposes of this worksheet any assumed premium subject to proportional retrocessional agreements reported here.]

Steps To Complete the Top Portion of Worksheet 10:

1. For each eligible reinsurance agreement, enter in column (a) the company's uniquely identifying number (or description) of the agreement.

2. For each reinsurance agreement, enter in column (b) the total direct earned premium for policies subject to proportional reinsurance.

3. For each reinsurance agreement, enter in column (c) the ceded earned premium.

4. In column (d) enter the proportion of risk reinsured, if and only if the ratio of ceded premium to direct premium is <u>not</u> used to represent the proportion of risk reinsured. In many situations the proportion will be a percent fixed by the reinsurance contract, e.g., 50% quota share. In other situations, e.g. excess of retention contracts, the proportion should determined based on total reinsured exposure to total direct exposure. For example, it is acceptable to use the ratio of ceded claim reserves to total claim reserves for disability income as an approximation of this percentage.

5. Enter in column (e) the ratio the direct premium from column (b) times the ratio of column (h) to column (c) for the appropriate line of business on the Principal Worksheet - Premiums. [For credit disability, use the values from line 6.3. For disability income, use the RBC value of line 7.1 plus 7.2, and divide by the value from line 7.1 column (c). For long-term care, use the RBC value of line 8.1 plus 8.2, and divide by the value from line 8.1 column (c).]

6. If you have entered a value in column (d), enter in column (f) the product of (d) times (e). Otherwise, enter (e) times (c) divided by (b).

7. Enter the totals of columns (c) and (f), and enter as the average factor the ratio of the total of column (f) to the total of column (c).

Worksheet 10 Ceded Quota Share and Other Proportional Reinsurance							
(a) Reins Acct#	(b) Direct Premium	(c) Ceded Premium	Proportion of Risk Ceded	(e) Direct RBC	(f) Ceded RBC		
Totals Average Factor							





Steps to Complete the Bottom Portion of Worksheet 10:

This portion is an optional worksheet designed to compute the RBC credit associated with the rate guarantee adjustment and the rate approval adjustment for proportional reinsurance. Such adjustments apply only to medical expense reimbursement, dental, and other inflationary lines of business.

The results of this worksheet are carried forward to Worksheet O.2.a, line (b) and Worksheet O.2.d, line (c). This portion of Worksheet 10 should be included only if the reinsurers' premiums can be changed only when the direct premiums change. In other words, this portion of the worksheet cannot be used if the reinsurer has the contractual right to change the premiums at any time other than when the direct premiums change.

1. Column (g) - This is the company's uniquely identifying number for the reinsurance program from column (a), above, for which some premium is subject to rate guarantees or rate approval.

2. Column (h) - This is the amount of premium ceded if any is subject to the rate guarantee adjustment or the rate approval adjustment. It should equal column (c) for the reinsurance agreement.

- 3. Column (i) This is the percent of the subject premium which is subject to a rate guarantee exceeding 15 months.
- 4. Column (j) This is the number of months of the rate guarantee.
- 5. Column (k) The factor from the gray area for the appropriate rate guarantee period.
- 6. Column (1) Equals column (h) times column (i) times column (k).
- 7. The total for column (l) is transferred to Worksheet O.2.a, line (b).
- 8. Column (m) [columns related to rate approval adjustment, for which instructions have not been completed]

			(m)			
(g)	(h)	(i)	(j)	(k)	(1)	Rate
Reins Acct#	Ceded	Pct Subject to	Period of	RBC Factor	Additional	Approval
	Premium	a Guarantee	Guarantee		RBC Credit	Adjmt 🚬
			:			
	1			Total	<u> </u>	



Instructions for HORBC Worksheet 11

Purpose of this Worksheet:

To calculate the HORBC C-2 factor to be applied to reinsurance premiums assumed under quota share and other proportional reinsurance agreements.

"Proportional reinsurance" as used in these HORBC Worksheets means reinsurance where the reinsurer's share of any given loss is a constant proportion of the direct writer's loss. The most obvious example of proportional reinsurance is quota share or coinsurance in which the reinsurance premiums and losses are a constant proportion of the direct premiums and losses. The reinsurance premiums themselves, however, need not necessarily be proportionate to the direct premium; for example: on reinsurance of the excess of a monthly income benefit retention on disability policies, in modified coinsurance, or where the reinsurance premium is attained-age-based (e.g., YRT) while the direct premium is issue-age-based.

In developing the RBC for assumed reinsurance, the company may use the most recent data information received from its reinsureds if it is less than a year old.

[Note: while the instructions below generally refer to "direct" premium, that term is intended to include for the purposes of this worksheet any assumed premium resulting from proportional retrocessional agreements reported here.]

Steps To Complete the Top Portion of Worksheet 11:

1. For each eligible reinsurance agreement, enter in column (a) the company's uniquely identifying number (or description) of the agreement.

- 2. For each reinsurance agreement, enter in column (b) the assumed earned premium.
- 3. Data to be entered in columns (c), (d), and (e) are to be obtained from the reinsured:

Column (c) is ceded premium, from reinsured's Worksheet 10, column (c).

Column (d) is ceded RBC, from reinsured's Worksheet 10, column (f).

Column (e) is the managed care credit factor (MCCF) (if applicable), from reinsured's Worksheet 1.1 (for medical coverages) or 2.1 (for dental coverages).

4. Enter in column (f) the result of column (b) times the ratio of column (d) to column (c), times (1 - adjusted MCCF). The adjusted MCCF lesser of the reinsured's MCCF or the Category 1 factor from Worksheet 1.1 or 2.1.

5. Enter the totals of columns (b) and (f), and enter as the average factor the ratio of the total of column (f) to the total of column (b).

Worksheet 11 Assumed Quota Share and Other Proportional Reinsurance							
(a) Reins Acct#	(b) Assumed Premium	(c) Ceded Premium	(d) Ceded RBC	(e) Managed Care Factor	(f) Assumed RBC		
Totals							
Average Factor							



Steps to Complete the Bottom Portion of Worksheet 11:

This portion is an optional worksheet designed to compute the additional RBC for proportional reinsurance associated with rate guarantee adjustments and the rate approval adjustments. Such adjustments apply only to medical expense reimbursement, dental, and other inflationary lines of business.

The results of this worksheet are carried forward to Worksheet O.2.a, line (d) and Worksheet O.2.d, line (e). This portion of Worksheet 11 should be included if the reinsurer's premium rates can be changed only when the direct premiums change or if the reinsurer's premium rates to its reinsured are guaranteed for more than 15 months.

1. Column (g) - This is the company's uniquely identifying number for the reinsurance program from column (a), above, for which some premium is subject to rate guarantees or rate approval.

2. Column (h) - This is the amount of assumed earned premium if any is subject to the rate guarantee adjustment or the rate approval adjustment. It should equal column (b) for the reinsurance agreement.

3. Column (i) - This is the percent of the subject premium which is subject to a rate guarantee exceeding 15 months, as determined from the reinsured's records.

4. Column (j) - This is the percent of the subject premium for which the reinsurer has guaranteed its premium rates to the reinsured for a period exceeding 15 months.

- 5. Column (k) This is the number of months of the rate guarantee.
- 6. Column (1) The factor from the gray area for the appropriate rate guarantee period.
- 7. Column (m) Equals column (h) times the sum of column (i) and column (j) times column (l).
- 8. The total for column (m) is transferred to Worksheet O.2.a, line (d).
- 9. Column (n) [columns related to rate approval adjustment, for which instructions have not been completed]

			(n)				
(g) Reins Acct#	(h) Assume d Premium	(i) Pct Subject to a Guarantee by Reinsured	(j) Pct Subject to a Guarantee by Reinsurer	(k) Period of Guarantee	(l) RBC Factor	(m) Additional RBC Credit	Rate Approval Adjmt
					Total		



Instructions for Principle Worksheet - Other Risks

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Line 0.2 - The Non-cancelable (NC) Net Earned Premium comes from Schedule H - Part 1 Column 5 Line 2 for L&H and P&C Blanks. For HMO and HMDI filers, the information comes from company records.

Line 0.3 - The amount is the sum of c(ii) and c(iii) from General Interrogatory #___(37 for L&H, 36 for P&C, 25 for HMDI and 29 for HMO).

Line 0.4 - The Claim Reserve for each specific type of coverage is to come from company records. It is the portion for each type of:

Schedule H - Part 2C Line 1 for L&H and P&C Blanks. Schedule H, Section II, Line 5, column 4 for the HMO Blank Underwriting and Investment Exhibit, Part 2, Line 5, column 3 for the HMDI Blank.

:

INSTRUCTIONS FOR WORKSHEET 0.1

Line] Enter the amount reported as assessments other than guarantee fund assessments from the current

- year general interrogatory
 Line 2 Enter the amount reported as assessments other than guarantee fund assessments from the prior year general interrogatory
 Line 3 Enter the amount reported as assessments other than guarantee fund assessments from the previous prior year general interrogatory
 Line 4 Enter Total Direct Medical Premiums from Primary Worksheet Premiums (Line 1.6 Column (c)) for the current year
 Line 5 Enter Total Direct Medical Premiums from Primary Worksheet Premiums (Line 1.6 Column (c)) for the prior year
 Line 6 Enter Total Direct Medical Premiums from Primary Worksheet Premiums (Line 1.6 Column (c)) for the prior year
- Line 7 Line 4 / Line 1
- Line 8 Line 5 / Line 2
- Line 9 Line 6 / Line 3
- Line 10 Enter the greatest of lines 7, 8, or 9
- Line 11 Enter the smallest of lines 7,8, or 9
- Line 12 Line 10 Line 11
- Line 13 Absolute value of Line 12 x Line 4

HORBC WORKSHEET INSTRUCTIONS RATE GUARANTEE ADJUSTMENT WORKSHEET 0.2.a

- Line .1 Sum the premium amounts from column (c) in the C-2 Principal Worksheet-Premiums for lines 1.6, 2.1, 3 and 9.1.
- Line .2 Percent of direct premium in Line .1 with rates that will or can be changed in less than 16 months from their effective date, based on company records.
- Line .3 Percent of direct premium in Line .1 with rates that will or can be changed only after 16 months from their effective date and less than 36 months from their effective date, based on company records.
- Line .4 Percent of direct premium in Line .1 with rates that will or can be changed only after 36 months from their effective date, based on company records.
- Line a Multiply the premium amount from line 0.1 times the sum of the percentage from line 0.3 times 2511RV and the percentage from line 0.4 times .673RV Line b RBC amounts from Worksheet 10 total lines for column (m).
- Line c RBC amounts from Worksheet 1.3 total lines for columns (m).
- Line d RBC amounts from Worksheet 11 total lines for columns (n).
- Line e RBC amounts from Worksheet 1.4 total lines for columns (n).
- TOTAL Line a Line b Line c + Line d + Line e

RATE APPROVAL ADJUSTMENT

1.a Rate changes up to a pre-approved trend allowed - Premium Medicare Risk

Enter earned premium for Medicare Risk contracts where rate increases can be made for pre-approved anticipated trend amounts without further approval.

1.b Rate changes up to a pre-approved trend allowed - Premium Medicaid Risk

Enter earned premium for Medicaid Risk contracts where rate increases can be made for pre-approved anticipated trend amounts without further approval.

1.c Rate changes up to a pre-approved trend allowed - Premium Other

Enter earned premium other than Medicare or Medicaid risk contracts where rate increases can be made for pre-approved anticipated trend amounts without further approval.

1.d Rate changes up to a pre-approved trend allowed - Total

Total line 1 column a. b. and c.

2.a All Other Approvals - Premium Medicare Risk

Enter earned premium for Medicare Risk contracts where all rate increases must be approved.

2.b All Other Approvals - Premium Medicaid Risk

Enter earned premium for Medicaid Risk contracts where all rate increases must be approved.

2.c All Other Approvals - Premium Other

Enter earned premium other than Medicare or Medicaid risk contracts where all rate increases must be approved.

2.d All Other Approvals - Total.

Total line 2 column a. b. and c.

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3.a Percentage of line 2 with approval with 45 days - Medicare Risk

Percentage of Medicare Risk rate increases contracts where all rate increases must be approved and which have historically been approved within 45 days.

3.b Percentage of line 2 with approval with 45 days - Medicaid Risk

Percentage of Medicaid Risk rate increases contracts where all rate increases must be approved and which have historically been approved within 45 days.

3.c Percentage of line 2 with approval with 45 days - Other

Percentage of earned premium other than rate increases contracts where all rate increases must be approved and which have historically been approved within 45 days.

- 6. [1.d x .092 x RV] + [2.d x .184 x RV]
- 7. $[.092 \times RV \times (1.d 3.d)] + [.46 \times RV \times 4.d]$

8. [Lesser of line 6. or 7.] x [1 - managed care factor from worksheet 1.1]

9. Ceded - quota share/proportional

Enter additional RBC from worksheet 10.

10. Ceded - non-proportional

Enter additional RBC from worksheet 1.3.

11. Assumed - quota share/proportional

Enter additional RBC from worksheet 11.

12. Assumed - non-proportional

Enter additional RBC from worksheet 1.4.

13. Total

Add lines 8., 11. and 12. less lines 9. and 10.



CREDITS FOR RSRs, DIVIDEND AND RETRO RATE ADJUSTMENTS

General Instructions:

Rate stabilization reserves (RSR), for this purpose, include amounts which: (1) appear on the company's liability page, (2) are available for use by the company to offset unexpected losses and are not required to cover anticipated losses, and (3) are not required to be held in order to satisfy other statutory obligations such as a valuation law. They do not include reserves held for retired lives and gross premium valuation reserves. Where the policy holder is an agency of the federal government, where that agency holds a rate stabilization reserve, and where there is contractual language which puts such a reserve totally at risk to pay for premium short falls, such reserve will be treated as though the insurer were holding the reserve.

Show subtotals for rate stabilization reserves for non-federal government programs, for federal government programs where a federal agency holds the RSR, for dividends and for retrospective rate adjustments. For carriers filing the Life or P&C annual statement blanks the RSR for non-government programs should not exceed the insert to line 11.2 on page 3 and dividends should not exceed line 10 column(2) of schedule H - Part 1.

(a) Group Identifier

Internal identifier used by the health organization for the group which qualifies for the rate stabilization reserve, dividend or retrospective rate adjustment.

(b) Type of Health Insurance

Enter type of health insurance per the categories used on the Principal worksheet. e.g. medical, dental, etc.

(c) Direct or Assumed Premium

Annual earned direct or assumed premium for this group.

(d) Allocated Direct or Assumed RBC

This is a calculation of the direct RBC applicable to this group using an average RBC per dollar of direct earned premium or the RBC calculated for the group on worksheet 11 for assumed premium. for direct premium divide the appropriate total (column h. of the Principal Worksheet) RBC by the corresponding total direct premium (column c. of the Principal Worksheet) and multiply the resulting ratio by the direct premium in column c of this worksheet.

(e) RSR, Div or Retro Amount

Enter the rate stabilization reserve, dividend paid or maximum retrospective rate adjustment payable for this group. If the RSR is for a Federal Employee Health Benefit Plan enter the amount held by the federal government that is allocated to this contract. Rate stabilization reserves credits can only be taken if based the experience of the specific group identified in column a. That is, RSR credit can not be taken if the RSR is held for a block of business in total.

(f) Ceded RBC

Calculate the ceded RBC as ceded premium x 1.85 x column d divided by column c.

(g) Number of Lives

Number of lives covered counting dependents as individual lives. If detail for lives is not available, use number of certificates without adjustment for family composition.

(h) Value of 'P'

For retrospective premiums that are not secured by a letter of credit or funds on deposit with the health organization 'P' is the greater of 1% or .01 x $[(500 + (g)) \div 2(g)]$. For RSRs and dividends 'P' is .01 x $[(500 + (g)) \div 2(g)]$.

(i) RBC Offset

Lesser of (e) or (d) - (f) - [(h) x (c)]