



AMERICAN ACADEMY *of* ACTUARIES

December 3, 2005

To: Mr. Louis Felice, Chair, NAIC Capital Adequacy (E) Task Force

From: John Fritz, Chair, American Academy of Actuaries¹ Medicare Part D Subgroup

Re: Report on Proposed RBC Risk Factors to Address Medicare Part D Coverage.

Dear Mr. Felice,

The American Academy of Actuaries' Medicare Part D RBC Subgroup wishes to present the attached as our report on proposed RBC risk factors relating to the insurance of Medicare Part D coverage commencing January 1, 2006. This report was written by our Subgroup in response to your charge, given during the Summer NAIC Meeting that was held in Boston, June 11-14, 2005.

We appreciate the opportunity to provide this report and look forward to your feedback. If there are any questions regarding this report or our previous submissions of proposed RBC changes in response to Medicare Part D, I invite you to contact Geralyn Trujillo, staff liaison to the Subgroup, at (202) 785-6924 or trujillo@actuary.org.

Sincerely,

John F. Fritz
Chair, Health RBC Subgroup
Task Force on Health RBC
American Academy of Actuaries

CC: Julia Philips, Chair of Health RBC Subgroup, Capital Adequacy (E) Task Force
Dan D. Swanson, NAIC Staff Liaison
Alan Ford, Chair, Academy Task Force on Health RBC
Michael Abroe, Vice President, Academy Health Practice Council

Attachments: Report on Risk Factors for Medicare Part D

¹ The American Academy of Actuaries is the public policy organization for 15,000 actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the actuarial profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also supports the development and enforcement of actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

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AMERICAN ACADEMY *of* ACTUARIES

**HEALTH RISK-BASED CAPITAL AND
MEDICARE PART D: REPORT TO THE CAPITAL
ADEQUACY TASK FORCE OF THE NATIONAL
ASSOCIATION OF INSURANCE
COMMISSIONERS**

**American Academy of Actuaries
Medicare Part D Subgroup
December 2005**

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I. The Charge to the Subgroup.

The NAIC Capital Adequacy Task Force (“the Task Force”) asked the American Academy of Actuaries (“the Academy”) to recommend an appropriate Risk-Based Capital (“RBC”) treatment for the Medicare Part D coverage that will commence on January 1, 2006. For the purpose of responding to this request, the Academy’s Task Force on Health Risk-Based Capital formed a Medicare Part D RBC Subgroup (“the Subgroup”).

In September of 2005, the Subgroup provided a recommendation to the Task Force regarding changes to the RBC formula structure and instructions that would address the risk considerations that are specific to Medicare Part D. Changes were recommended for both the Health RBC formula and the Life RBC formula. These changes involved the introduction of several additional factors for Medicare Part D, but the recommendation at that time did not include actual numerical values for those factors.

In this report, we recommend numerical values for the factors specific to Medicare Part D, and provide the rationale for our recommendations. Many of the capitalized terms used in this report are defined in the RBC instructions that we submitted to the Task Force in September.

The members of the Subgroup who participated in the development of this report include: John Fritz, chairperson; Frank Amrine; Terry Arthur; Corey Berger; John Bertko; James Braue; Clint Copeland; Karl Madrecki; Cindy Miller; Donna Novak; Rebecca Owen; Leigh Wachenheim; William Weller; and Jon Zapolski.

II. Recommendations.

In this section, we give a summary description of the new RBC factors required for Medicare Part D and recommend factors to be used for 2006 and 2007.

A. Required Factors.

The proposed RBC formula structure requires the following additional factors.

- There are two Underwriting Risk Factors applicable to Standard Coverage: a factor applicable to annual premium up to specified dollar breakpoint, and another factor applicable to annual premium in excess of that breakpoint. Below, we refer to those factors as the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor, respectively. These factors are used on page XR011 of the Health RBC formula and page LR017 of the Life RBC formula.
- There are four discount factors that reduce the required Underwriting Risk RBC for Standard Coverage, depending on which of the federal risk mitigation features are applicable (see section III below). However, only two factors are expected to be applicable during the period 2006-2011, viz., the factor for payments subject to both the Reinsurance Coverage and the Risk-Corridor Protection, and the factor for payments subject to only the Risk-Corridor Protection. These factors are used on page XR016 of the Health RBC formula and page LR019 of the Life RBC formula.
- There is another Underwriting Risk Factor applicable to premium received for Supplemental Benefits. No discount factors are applicable. This factor is used on page XR013 of the Health RBC formula and page LR016 of the Life RBC formula.

Note that these factors apply only to business written as stand-alone coverage by a PDP Sponsor (i.e., a legal entity providing Medicare Part D as a stand-alone coverage, rather than as part of a Medicare Advantage plan). Medicare Part D coverage that is integrated with a Medicare Advantage plan is included in Comprehensive Medical coverage along with the rest of the business. Government-subsidized employer-plan-based prescription drug coverage either is included with Comprehensive Medical coverage, if it is part of an insured medical plan, or is treated as “Other Health” if it is a stand-alone insured coverage.

Note also that the factors for Standard Coverage also will apply to coverage that is actuarially equivalent to Standard Coverage. Although it is conceivable that actuarially equivalent coverage could be subject to materially different underwriting risk, the members of the Subgroup, based on such information as they have available, have concluded that the differences in risk are likely to be immaterial in most circumstances.

Attached, for reference, are our recommended changes to the Health and Life RBC formula structures and instructions.

B. Recommended Factors for 2006-07.

For the period 2006-07, during which the initial level of Risk-Corridor Protection applies, we recommend the following factor values.

Underwriting Risk Factors for Standard Coverage:	
• Initial Factor	0.141
• Excess Factor	0.109
Discount Factors for Standard Coverage:	
• Risk-Corridor Protection only	0.500
• Reinsurance Coverage and Risk-Corridor Protection	0.650
Underwriting Risk Factor for Supplemental Benefits	0.120

Furthermore, we recommend that the dollar breakpoint for the Underwriting Risk Factors for Standard Coverage be \$25 million dollars. This breakpoint applies to both the Health RBC formula (on page XR011) and the Life RBC formula (on page LR017).

Note that the discount factors are expressed as reductions of the RBC that would otherwise be required. For example, the factor of 0.650 means that the required RBC would be reduced by 65%.

C. Recommendation for Future Years.

As the risk mitigation features of the Part D Program change over time, this recommendation should be revisited since the reduced value of the Risk Corridor Protection will reduce the discount factors. Specifically, we strongly recommend that another similar study be performed after the Plans file Part D bids for the 2008 calendar year in June, 2007 to appropriately modify the above factors for the 2008-2011 period and possibly reflect significant benefits differences that have developed during the initial two years.

III. Risk-Mitigation Features of Medicare Part D.

The federal statute that established Medicare Part D contains several features that are intended to mitigate the financial risk to those entities that provide Medicare Part D coverage. This section provides summary descriptions of those features.

A. Health Status Risk Adjustment.

Medicare Part D premiums will be adjusted to reflect the relative anticipated levels of benefit costs for individual enrollees. This risk adjustment is based on individual health status and is intended to align the premiums more closely with the expected benefit costs of the specific enrolled population. Accordingly, the risk adjustment should reduce the chances that an entity providing Medicare Part D coverage will experience adverse financial results simply because an above-average number of high-cost individuals enroll with that particular entity. The adjustment factors, or “risk adjusters,” will be determined annually in advance of the annual coverage period.

B. Reinsurance Coverage.

Generally, when benefit costs under Standard Coverage exceed a specified out-of-pocket threshold, the federal government will be financially responsible for 80% of those excess costs. The enrollee will pay 5% of the excess (or specified co-payments, if greater); the remainder of the excess (typically, 15%) will remain the responsibility of the entity providing the Medicare Part D coverage. The federal government’s assumption of 80% of the excess costs is referred to as “Reinsurance Coverage.” Note, however, that this feature will not be accounted for as reinsurance under the accounting guidelines currently being considered by the NAIC; instead, the excess costs will be considered to be part of a government-sponsored uninsured plan.

Some coverage providers may participate in a Part D Payment Demonstration, pursuant to which they would receive a pre-determined additional per-enrollee payment in lieu of the 80% Reinsurance Coverage. These entities would therefore not receive the risk-mitigation benefit of the Reinsurance Coverage. Note, however, that the additional costs borne by these entities would be subject to the Risk-Corridor Protection described in section III.C, below.

C. Risk-Corridor Protection.

The federal government will adjust its payments to the entity providing the Medicare Part D coverage, based on the degree to which actual benefit costs vary from the level that was anticipated (the “target amount”) in the entity’s bid for its Medicare Part D contract. The government establishes thresholds for symmetric risk corridors above and below the target amount, defined as percentages of that target amount. Depending on where the actual benefit costs fall within those corridors, a specified percentage of the deviation (favorable or adverse) from the target amount will be retained by the entity providing the coverage, and the remaining benefit or cost will be passed on to the government.

The law creating Medicare Part D provided specific risk-corridor thresholds and risk-sharing percentages for 2006-07, and a different set of thresholds and percentages for 2008-2011. The law provides that the risk-corridor protection will continue after 2011, but that the corridors may be redefined at the discretion of federal regulators.

For 2006-07, the risk corridors thresholds are set at $\pm 2.5\%$ and $\pm 5.0\%$. If actual benefit costs to the entity fall within $\pm 2.5\%$ of the target amount, the entity retains the full deviation. If actual benefit costs fall between the 2.5% and 5.0% thresholds, then 75% (possibly 90% under certain circumstances) of the deviation between those thresholds is assumed by the government; i.e., if experience is worse than anticipated, the government will make an additional payment to the entity equal to 75% of the deviation beyond 2.5%, and if experience is better, then the entity must pay 75% of the deviation beyond 2.5% to the government. If actual benefit costs fall beyond either of the 5.0% thresholds, then in addition to the 75% payment there will be a payment of 80% of the deviation beyond that second threshold.

For 2008-11, the risk corridors are widened to $\pm 5.0\%$ and $\pm 10.0\%$, and the 75% factor is reduced to 50%; the 80% factor is unchanged. For 2012 and later, the thresholds can be reset, but the threshold percentages must be at least 5.0% and 10.0% respectively.

In the context of RBC, the importance of the risk corridors arises from their impact when benefit costs are greater than expected. For example, if in either 2006 or 2007 actual benefit costs are 120% of the target amount, the PDP Sponsor does not bear the entire 20% adverse deviation. Instead, its costs are limited to 6.125% (the first 2.5% of the target amount, plus 25% of the next 2.5%, plus 20% of the additional 15% deviation). Clearly, the risk-corridor protection can substantially reduce the risk borne by an entity that provides Medicare Part D coverage.

IV. Methodology.

The primary basis for the Subgroup's recommendations was information obtained through a survey of selected actuaries. Further details about the survey process and the analysis of survey responses are given in the remainder of this section.

A. The Survey.

A copy of the survey is attached. Responses to the survey were received and compiled by Academy staff, in order to maintain the confidentiality of the information provided.

1. Purpose of Survey.

In the past, the Academy's recommendations of underwriting risk factors for health coverages have typically been developed using models based on historical experience. The Academy was able to gather large volumes of relatively homogeneous loss ratio experience for the relevant category of health coverage, comprising several years of data from a broad cross-section of contributing companies. The data were analyzed using rigorous statistical modeling techniques, to estimate the minimum capital levels needed to avoid ruin at appropriate confidence levels.

Because Medicare Part D is a new program, there is no historical experience for the program per se. Although some other historical pharmacy experience might be available, it would be difficult if not impossible to identify or develop relevant data in a credible volume, given the special features of the Medicare Part D program (demographics, potential for antiselection, unknown impact of the risk adjusters, etc.). Therefore, the Subgroup had to adopt a more judgmental approach to the analysis. This is not unprecedented; in fact, the existing underwriting risk factors for "Other Health" — the factors that would presumably apply to Medicare Part D if the RBC formulas were not revised — were developed using actuarial judgment, taking into account the relative levels of the factors that had been statistically derived for the other, more specific categories of coverage.

Rather than relying solely on the knowledge and judgment of the relatively small number of actuaries participating directly in the Subgroup, we chose to seek opinions from other actuaries whom we believed to have some knowledge relevant to Medicare Part D. We developed a set of questions that we felt would enable us to identify a consensus viewpoint, or at least a central tendency of views, while providing us the opportunity to analyze some of the key factors underlying the responses to the questions.

2. Solicitation Criteria and Response Rate.

The actuaries whom we selected to receive the survey were those whom we could identify, or whose companies we could identify, as having been involved in the submission of Medicare Part D contract bids to the federal government. We felt that these were the people who would be most likely to have well-informed opinions on the

subject matter of the survey, and who would be in the best position to perform additional analysis of their own if necessary to answer the survey questions. To assist in the selection process, we asked CMS to provide the Academy with a list of the actuaries that certified the Part D bids for their respective companies. Using this list, we selected the listed actuaries for seven of the nine national Part D carriers, seven consulting actuaries and 16 others attempting to spread the selection among Blue Cross/Blue Shield plans, small and large health plans and insurance companies.

The subgroup solicited responses from these 30 actuaries. Follow-up calls were made by Academy staff to maximize the response rate. Complete or partial responses were received from nine of the survey recipients in time to be included in our analysis. In addition, three members of the Subgroup submitted responses to the survey based on their own familiarity with this area of work. Given that these latter responses tended to be somewhat more conservative than the responses from industry at large, we believed it was appropriate to simply include these responses with the others received, so that our analysis was based on twelve responses in total. We consider that to be a sufficient number of responses for the present purpose. However, we tended to take a more conservative approach to selecting the factors than we might have done if a larger number of responses had been received.

B. Analysis Methods.

The survey responses formed the basis for our analysis, both quantitative and qualitative, of the key features of Medicare Part D underwriting risk. Our methods of analysis are described immediately below. A copy of the Excel spreadsheet that was used in our analysis is attached (with illustrative data only).

1. Value of Health Status Risk Adjustment.

We compared the responses to survey questions #1 and #3 to the responses to #2 and #4, respectively, in order to judge whether some respondents were placing undue reliance on the efficacy of the health status risk adjustment. To the extent that the responses to #2 and #4 appeared to be excessively sanguine in that regard, we adjusted the answers judgmentally to reflect something closer to the typical view of how effective the health status risk adjustment will be.

2. Underwriting Risk Factors for Standard Coverage: Dollar Breakpoint.

We expect that, as with most other categories of business, small volumes of business will have materially more volatile experience than large volumes. The RBC formulas have historically reflected this relationship between volatility and volume through the use of tiered factors: one factor is applied to premium revenue (or some other measure of exposure) up to a specified level (the “breakpoint”), and a lower factor is applied to revenues in excess of that level. In some cases, more than two tiers of factors are used.

The current breakpoint for comprehensive medical coverage is \$25 million. The breakpoints for Medicare Supplement and for stand-alone dental coverage are each \$3 million. (In the Life RBC formula, that breakpoint applies to stand-alone dental and stand-alone vision coverages combined.) Our preference was to use one of these existing breakpoints for Medicare Part D, simply as a matter of convenience; it seemed likely that one or the other would be appropriate, depending on whether the volatility was more consistent with other limited-benefit coverages such as dental and vision, or whether it behaved more like the volatility of a high-dollar benefit such as comprehensive medical coverage.

Survey question #7 directly solicited the opinions of the respondents as to where a reasonable breakpoint would fall. Although we asked about breakpoints of \$3 million and \$25 million specifically, we also gave the respondents the option of providing alternative breakpoints as well.

In addition, we asked (through questions #5 and #6) that the responses to questions #1 through #4 be provided for differing volumes of business, so that we could judge from the responses at what breakpoint (if any) there seemed to be a significant decline in volatility.

3. Underwriting Risk Factors for Standard Coverage: Numerical Values.

First, we note that the basic Underwriting Risk Factors per se, without adjustment, are not expected to apply to any business based on the draft formula and instructions. At present, these factors only serve as a basis to which the Discount Factors will be applied. Accordingly, the absolute level of the factors is of little practical significance, as raising or lowering the factors should simply cause the Discount Factors to be raised or lowered in a consistent fashion. However, the proportionality between the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor is important, since that proportionality will be preserved even after the application of the Discount Factors.

For the Underwriting Risk Initial Factor, we chose a factor that would be roughly consistent with the 12% factor that is applied to “Other Health” premium in the Life RBC formula. Because the Underwriting Risk Initial Factor is applied to claims rather than premium, we had to adjust the percentage; see section IV.C.2 below.

Our analysis regarding the Discount Factors, as described in section IV.B.4 immediately succeeding, provided us with the desired proportionality between the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor. Again, see section IV.C.2 below.

4. Discount Factors.

Our development of recommended Discount Factors for Standard Coverage was based on the responses to survey questions #2 and #4, as modified by the responses to questions #5 and #6, and also reflecting the responses to question #8.

We considered separately the responses to questions #2 and #4 for volumes of business above and below the breakpoint that we had selected based on the analysis described in section IV.B.2 above. For each volume range, we considered the following two scenarios:

- (a) A single year of the “reasonably worst case scenario” as defined in the survey.
- (b) Three years of experience, where a single year at expected benefit cost levels is followed by two years of the “moderately adverse case scenario,” as defined in the survey.

For both scenarios, we took into account the fact that the adverse experience would first reduce reported profits below the expected level, and only after profits were totally eliminated would the adverse experience have an effect on statutory net worth. Our estimate of expected profitability was based on the responses that we received to survey question #8.

For each response within each scenario, we imposed a minimum adverse result of 2% of claims; i.e., if the response would have produced a result of less than 2% for a particular scenario, then we replaced that result with 2% in our analysis. The 2% minimum value was chosen because it is the factor that the RBC formulas apply to the Federal Employees Health Benefits Program; the Subgroup believes that this factor represents a reasonable floor for a risk charge applicable to Medicare Part D.

Having reviewed the results for each scenario, we tried to select factors that were representative of the responses provided, without giving much weight to obvious outliers.

With respect to the discount factor for Risk-Corridor Protection alone, we started with the responses to survey question #4. For each indicated degree of deviation from the expected level of benefit costs, we applied the risk corridors that are explained in section III.C above. We then used those mitigated deviations to obtain results for scenarios (a) and (b), reflecting also the expected level of profitability. We selected representative factors. By relating these factors to the Underwriting Risk Factors that we had already selected, we determined an appropriate level of discount for the application of the risk corridors. Note that we had to select a single discount factor that would be appropriate for both the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor.

We followed essentially the same approach to developing the discount factor for Reinsurance Coverage and Risk-Corridor Protection together. In this case, however, we began with the responses to survey question #2 rather than #4, again as modified by the responses to questions #5 and #6. Again, we applied the risk corridors and calculated results for scenarios (a) and (b). Based on those results, we selected representative factors and related them to the previously selected Underwriting Risk Factors to determine an appropriate level of discount. As was the case for Risk-Corridor Protection alone, we had to select a single discount factor that would be appropriate for both tiers of the Underwriting Risk Factors for Standard Coverage.

5. Underwriting Risk Factor for Supplemental Benefits.

The Subgroup was unable to construct a compelling rationale for a new underwriting risk factor for Supplemental Benefits. We concluded that the most reasonable approach was to apply the “Other Health” factor that is currently used in the Life RBC formula, namely, 12% of premium. (The corresponding factor in the Health RBC formula is 13% of incurred claims, which typically we would expect would be less than 12% of premium. For reasons of simplicity and consistency, our September recommendations on formula structure incorporated the percent-of-premium approach in both formulas.) As noted previously, this is the factor that would normally apply to stand-alone prescription drug coverage, in the absence of any changes such as those we have recommended to reflect the special features of the Medicare Part D Standard Coverage.

C. Results of Analysis.

The results of the Subgroup’s analysis with respect to each recommendation are summarized below.

1. Underwriting Risk Factors for Standard Coverage: Dollar Breakpoint.

The responses to survey question #7 were as follows.

<u>Breakpoint</u>	<u>% in favor</u>
\$1 million	10%
\$3 million	20%
\$10 million	20%
\$25 million	50%

Although there was no clear consensus, certainly there was a bias toward the higher breakpoints. Also note that no respondent suggested a breakpoint greater than \$25 million.

For questions #2 and #4, the responses varied by volume of business in the following manner. (Values shown are the deviations in excess of expected benefit cost levels.)

Question #2a:

	<u>Mean value</u>	<u>Median value</u>
< \$3 million	32.2%	37.0%
\$3-25 million	25.5%	23.9%
> \$25 million	26.1%	22.5%

Question #2b:

	<u>Mean value</u>	<u>Median value</u>
< \$3 million	18.3%	20.0%
\$3-25 million	15.9%	12.5%
> \$25 million	12.1%	10.0%

Question #4a:

	<u>Mean value</u>	<u>Median value</u>
< \$3 million	40.9%	35.0%
\$3-25 million	37.6%	28.4%
> \$25 million	32.9%	32.8%

Question #4b:

	<u>Mean value</u>	<u>Median value</u>
< \$3 million	24.0%	17.5%
\$3-25 million	22.3%	15.2%
> \$25 million	17.0%	16.7%

The progression of values is somewhat distorted by the fact that we received fewer responses for the \$3-25 million range than for the other ranges. However, it seems reasonably clear that, in the opinion of the respondents, the risk does decline as the volume of business increases. We also considered that \$3 million of annual premium is a fairly small volume of business (probably fewer than 3,000 lives), so that a \$3 million breakpoint would probably have minimal effect on most reporting entities.

In light of the above considerations, and desiring to provide for a reasonable degree of conservatism, we concluded that \$25 million would be an appropriate breakpoint.

2. Underwriting Risk Factors for Standard Coverage: Numerical Values.

As described in section IV.B.3 above, we began with the factor of 12% of premium that is currently applied in the Life RBC formula to “Other Health.” However, the proposed structure of the RBC formulas relating to Medicare Part D calls for the factor to be stated in terms of incurred benefit costs. It seems reasonable to suppose that, under normal circumstances, the loss ratio for this business will be between 80% and 90%, so that 12% of premium would be equivalent to between 13.3% and 15.0% of benefit costs. In particular, if a loss ratio of 85% is assumed, then the factor in terms of benefit costs would be 14.1%. This was our choice for the Underwriting Risk Initial Factor.

In the course of our analysis of the Discount Factors (as described in section IV.C.3 immediately succeeding), we selected preliminary factors to apply to volumes of business above and below the breakpoint of \$25 million. With respect to the factors for Risk-Corridor Protection, the preliminary factor for volumes above the breakpoint was 79% of

the preliminary factor for volumes below the breakpoint; with respect to the factors for Reinsurance Coverage and Risk-Corridor Protection, the corresponding proportion was 76%. Taking the average of those two proportions, 77.5%, as reasonable, we calculated an Underwriting Risk Excess Factor of 10.9% (77.5% of the 14.1% Underwriting Risk Initial Factor). Keep in mind that, as discussed further below, this 10.9% factor is a marginal factor applicable only to the portion of premium in excess of the breakpoint; it serves as an asymptotic limit to the effective average factor for a volume of business, so that even for extremely large volumes of business the effective factor is never as low as 10.9% (though for very large volumes the difference is negligible).

Accordingly, we are recommending that the Underwriting Risk Initial Factor be 0.141, and that the Underwriting Risk Excess Factor be 0.109. Note again that these Underwriting Risk Factors themselves, without any discount, are not expected to apply to any business in the foreseeable future. These factors only serve as a basis to which the Discount Factors will be applied.

Also recall that for a volume of business above the breakpoint, the effective factor will be a weighted average of the two Underwriting Risk Factors; e.g., for \$50 million of annual premium, the effective factor would be 12.5% (14.1% on the first \$25 million and 10.9% on the additional \$25 million). Therefore, this choice of factors incorporates some additional conservatism, since the preliminary factors selected for volumes of business above the breakpoint actually represented something more comparable to the average, effective factor. For example, we concluded (see section IV.C.3 immediately succeeding) that 3.8% would be a reasonable factor for volumes of business above the breakpoint when both Reinsurance Coverage and Risk-Corridor Protection are applicable. In the \$50 million example just given, the after-discount factor would actually be 4.375% (the 12.5% factor calculated above, reduced by 65%), which is significantly higher (about 15%) than the 3.8% factor.

3. Discount Factors.

As noted above, we had a smaller number of responses for the \$3-25 million range of annual premium than we did for the ranges of less than \$3 million and greater than \$25 million. We felt that the credibility of the results for that intermediate range was thereby lessened significantly. Accordingly, we decided that for the purpose of determining appropriate discount factors, we would use only the responses for less than \$3 million and greater than \$25 million.

Our analysis for the Risk-Corridor Protection discount factor produced the following results for scenarios (a) and (b). (Note that, as explained in section IV.B.4 above, a minimum value of 2.00% was imposed on all responses for each scenario.)

	<u>Mean value</u>	<u>Median value</u>
Below \$3 million:		
• Scenario (a)	6.63%	5.13%
• Scenario (b)	4.92%	2.00%
Above \$25 million:		
• Scenario (a)	5.34%	4.69%
• Scenario (b)	2.83%	2.00%

Based on these results, we selected a preliminary factor of 6.7% applicable to volumes of business below the breakpoint, and a preliminary factor of 5.3% for volumes above the breakpoint. Relating these factors to the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor, respectively, generated discount factors of 0.525 and 0.514. We concluded that 0.500 would be a reasonable discount to apply in situations where only Risk-Corridor Protection was applicable to the business. Note that this discount produces effective factors of 7.05% below the breakpoint and 5.45% above the breakpoint.

Our analysis for the Reinsurance Coverage and Risk-Corridor Protection discount factor produced the following results for scenarios (a) and (b).

	<u>Mean value</u>	<u>Median value</u>
Below \$3 million:		
• Scenario (a)	4.91%	5.53%
• Scenario (b)	2.59%	2.00%
Above \$25 million:		
• Scenario (a)	3.83%	2.62%
• Scenario (b)	2.20%	2.00%

Based on these results, we selected a factor of 5.0% applicable to volumes of business below the breakpoint, and a factor of 3.8% for volumes above the breakpoint. Relating these factors to the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor, respectively, generated discount factors of 0.645 and 0.651. We concluded that 0.650 would be a reasonable discount to apply in situations where both Reinsurance Coverage and Risk-Corridor Protection were applicable to the business. Note that this discount produces effective factors of 4.935% below the breakpoint and 3.815% above the breakpoint.

We have considered the fact that the provision of Supplemental Benefits may affect the efficacy of the Reinsurance Coverage in reducing risk, since the out-of-pocket threshold will be achieved at a higher level of total expenses. We did not believe there is any practical way to incorporate this consideration directly into our current analysis.

However, we believe that the higher Underwriting Risk Factor that is applicable to Supplemental Benefits may serve in part to compensate for any such effect.

4. Underwriting Risk Factor for Supplemental Benefits.

As discussed in section IV.B.5 above, we concluded that we had no basis for recommending a factor other than is currently applicable in the Life RBC formula to “Other Health” coverages. Although the responses to our survey indicated a potentially high degree of variability in the experience for prescription drug coverage in the absence of the Medicare Part D risk-mitigation features, it is not clear that those responses are relevant to Supplemental Benefits, which could be fairly narrowly defined and closely controlled. Therefore, we are recommending that a factor of 0.120 be applicable to the annual premium for Supplemental Benefits.

V. Future Considerations.

Ultimately, the RBC factors applicable to Medicare Part D should be based on an analysis of actual experience for the coverage. However, it will be several years before a credible body of experience can be accumulated, and the analysis of that experience and the recommendation and adoption of RBC factors will require additional time.

Accordingly, it will not yet be possible for the Academy to use this approach for a recommendation for the 2008 RBC formulas. The reporting entities' additional experience with Medicare Part D should improve their ability to price the coverage, thereby reducing the potential for material deviations from expected levels of benefit costs. We therefore recommend that a study somewhat similar to the study undertaken for this recommendation be performed in 2007, modified as deemed appropriate from experience gained for Medicare Part D to that time, in order to develop appropriately modified factors for the four-year period, 2008-2011.

To facilitate further analysis for later year recommendations, we suggest that the NAIC adopt a standardized format for collecting Medicare Part D experience from the participating legal entities on an annual basis.

UNDERWRITING RISK – MANAGED CARE CREDIT

		(2)	(3)	(4)
		Paid Claims	Weighted Claims*	Part D Weighted Claims**
		Factor		
<u>Comprehensive Medical, Medicare Supplement and Dental Claim Payments</u>				
(1) Category 0 - Arrangements not Included in Other Categories	Company records	X 0.000	=	
(2) Category 1 - Payments Made According to Contractual Arrangements	Company records	X 0.150	=	
(3) Category 2a - Subject to Withholds or Bonuses – Otherwise Category 0	Company records	X †	=	
(4) Category 2b - Subject to Withholds or Bonuses – Otherwise Category 1	Company records	X ‡	=	
(5) Category 3a - Capitated Payments Directly to Providers	Company records	X 0.600	=	
(6) Category 3b - Capitated Payments to Regulated Intermediaries	Company records	X 0.600	=	
(7) Category 3c - Capitated Payments to Non-Regulated Intermediaries	Company records	X 0.600	=	
(8) Category 4 - Medical & Hospital Expense Paid as Salary to Providers	Company records	X 0.750	=	
(9) Sub-Total Paid Claims	Sum of Lines (1) through (8)			
<u>Medicare Part D Coverage Claim Payments</u>				
(x.1) Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company records	XXX X xxx	=	
(x.2) Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company records	XXX X xxx	=	
(x.3) Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company records	X 0.500	=	
(x.4) Category 3a - Federal Reinsurance and Risk Corridor Protection apply	Company records	X 0.650	=	
(x.5) Sub-Total Paid Claims	Sum of Lines (x.1) through (x.4)			
(x.6) Total Paid Claims	Sum of Lines (9) and (x.5)			
(10) Weighted Average Managed Care Discount	Col (3) is Col (3) Line (9) / Col (2) Line (9) Col (4) is Col (4) Line x.5/ Col (2) Line (x.5)			
(11) Weighted Average Managed Care Risk Adjustment Factor	1.0 - Line (10)			
Calculation of Category 2 Managed Care Factor (Comprehensive and Dental only)		(1) Amount		
(12) Withhold & bonus payments, prior year	Company Records			
(13) Withhold & bonuses available, prior year	Company Records			
(14) Managed Care Credit Multiplier – average withhold returned	Line (12) / Line (13)			
(15) Withholds & bonuses available, prior year	Line (13)			
(16) Claims payments subject to withhold, prior year	Company Records			
(17) Average withhold rate, prior year	Line (15) / Line (16)			
(18) Managed Care Credit Discount Factor, Category 2	Minimum of 0.25 or Line (14) x Line (17)			


* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental managed care discount factor.

** This column is for the Medicare Part D managed care discount factor.

- † Category 2 Managed Care Factor calculated on Line (18).
- ‡ Category 2 Managed Care Factor calculated on Line (18) with a minimum factor of 15 percent.

Denotes items that must be manually entered on the filing software.

		(1)
		RBC Amount
H3 - CREDIT RISK		
(31)	Total Reinsurance RBC	XR018, Credit Risk Page - L(17) _____
(32)	Intermediaries Credit Risk RBC	XR018, Credit Risk Page - L(24) _____
(33)	Total Other Receivables RBC	XR019, Credit Risk Page - L(30) _____
(34)	Total H3	Sum L(31) through L(33) =====
H4 - BUSINESS RISK		
(35)	Administrative Expense RBC	XR020, Business Risk Page - L(7) _____
(36)	Non-Underwritten and Limited Risk Business RBC	XR020, Business Risk Page - L(11) _____
(37)	Premiums Subject to Guaranty Fund Assessments	XR020, Business Risk Page - L(12) _____
(38)	Excessive Growth RBC	XR020, Business Risk Page - L(19) _____
(39)	Total H4	Sum L(35) through L(38) =====
(40)	RBC after Covariance	$H0 + \text{Square Root of } (H1^2 + H2^2 + H3^2 + H4^2)$ _____
(41)	Authorized Control Level RBC	.50 x RBC after Covariance _____

 Denotes items that must be manually entered on filing software.

* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental managed care discount factor.

HEALTH PREMIUMS and HEALTH CLAIM RESERVES

LR016, LR020 and LR021

Basis of Factors

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

Medical Insurance Premium

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

Disability Income Premium

Prior to 2001, the individual disability income factors were based on models of the disability risk completed by several companies with significant experience in this line. The group long-term disability income risk was modeled based on methodology similar to that used by one of the largest writers of this business. The pricing risk was addressed principally as the delayed reaction to increases in incidence of new claims and to the lengthening of claims from slower recoveries than assumed.

Long Term Care Insurance Premium

Prior to 2005, factors equal to the original disability income **factors** were used. Starting in 2005, factors based on LTC experience replace those factors. The difference in the factors used in 2004 and prior years for Noncancellable LTC versus other LTC has been retained as a Rate Risk factor applied to the NC premium. The Morbidity Risk is partially applied directly to premium with a higher factor applied to amounts up to \$50,000,000 and a lower factor applied to premiums in excess of \$50,000,000. In addition, the earned premiums and incurred claims for the last two years are used to determine an average loss ratio (**incurred claims divided by earned premiums**). This average loss ratio times the current year's premium is called Adjusted LTC Claims for RBC. A higher factor is applied to claims up to \$35,000,000 and a lower factor is applied to claims above \$35,000,000.

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

Claim Reserves

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

Pre-Tax and Post-Tax Factors

The formula uses pre-tax factors for all types of health insurance. Because many insurers of some types of health insurance write very little other business, it was determined that there would be no difference between pre-tax and post-tax factors except where substantial investment income is assumed as part of the product pricing. Thus, for disability income, the pre-tax factors on pages 26-28 and in LR020 Long-Term Care will be adjusted to post-tax by applying a tax-effect change to RBC in LR027. For reasons of practicality and simplicity, credit disability is included with other disability income and adjusted to post-tax. The pre-tax RBC values for other types of health insurance will not be adjusted.

Specific Instructions for Application of the Formula

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

Line (1)

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

Line (2)

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

Line (3)

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

Line (X.1)

Health premium for Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 3 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (1). No RBC requirement is calculated in Column (2). The premium is carried forward to page **LR017** Underwriting Risk – Experience Fluctuation Risk Column (4) Line (1.1).

Line (X.2)

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

Line (4) and Line (11)

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

Line (5) and Line (12)

The factor for Accidental Death and Dismemberment (AD&D) insurance (where a single lump sum is paid) depends on several items:

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

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

Line (6) and Line (13)

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

Line (7)

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

Line (8)

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

Line (10)

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

Line (Y.1)

Health premium for Medicare Part D coverage written on group contracts only if the plan sponsor has risk corridor protection for the contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor protection payments. See Appendix 3 for definition of these terms. Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (2726) Other Health. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (7). No RBC requirement is calculated in Column (2). The premium is carried forward to page LR017 Underwriting Risk – Experience Fluctuation Risk Column (4) Line (1.2).

Line (Y.2)

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

Lines (15) through (21)

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

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

	<u>Annual Statement Source</u>	<u>(1) Statement Value</u>	<u>Factor</u>	<u>(2) RBC Requirement</u>
<u>Disability Income Premium</u>				
<u>Line (15)</u>	Noncancellable Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part		
a)	First \$50 Million Earned Premium of Line (15)	Company Records		
b)	Over \$50 Million Earned Premium of Line (15)	Company Records	X 0.539 =	
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (15) + b) of Line (15), Column (2)	X 0.231 =	
<u>Line (16)</u>	Other Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part		
a)	Earned Premium in Line (16) [up to \$50 million less premium in a) of Line (15)]	Company Records	X 0.385 =	
b)	Earned Premium in Line (16) not included in a) of Line (16)	Company Records	X 0.108 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (16) + b) of Line (16), Column (2)		
<u>Line (17)</u>	Disability Income - Credit Monthly Balance	Earned Premium included in Schedule H, Part 1, Line 2, in part		
a)	First \$50 Million Earned Premium of Line (17)	Company Records	X 0.308 =	
b)	Over \$50 Million Earned Premium of Line (17)	Company Records	X 0.046 =	
c)	Total Disability Income - Credit Monthly Balance	a) of Line (17) + b) of Line (17), Column (2)		
<u>Line (18)</u>	Disability Income – Group Long Term	Earned Premium included in Schedule H, Part 1, Line 2, in part		
a)	Earned Premium in Line (18) [up to \$50 million less premium in a) of Line (17)]	Company Records	X 0.231 =	
b)	Earned Premium in Line (18) not included in a) of Line (18)	Company Records	X 0.046 =	

c)	Total Disability Income – Group Long Term	a) of Line (18) + b) of Line (18), Column (2)	_____	_____
<u>Line (19)</u>	Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part. This amount to be reported on Health Premiums, Line (19)	_____	
a)	Additional Reserves for Credit Disability Plans	LR016 Health Premiums Column (1) Line (29)	_____	
b)	Additional Reserves for Credit Disability Plans, Prior Year	LR016 Health Premiums Column (1) Line (30)	_____	
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (19) - a) of Line (19) + b) of Line (19)	_____	
d)	Earned Premium in c) [up to \$50 million less premium in a) of Line (17) + a) of Line (18)]	Company Records	_____	X 0.231 = _____
e)	Earned Premium in c) of Line (19) not included in d) of Line (19)	Company Records	_____	X 0.046 = _____
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (19) + e) of Line (19), Column (2)	_____	_____
<u>Line (20)</u>	Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part	_____	
a)	Earned Premium in Line (20) [up to \$50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19)]	Company Records	_____	X 0.154 = _____
b)	Earned Premium in Line (20) not included in a) of Line (20)	Company Records	_____	X 0.046 = _____
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (20) + b) of Line (20), Column (2)	_____	_____
<u>Line (21)</u>	Disability Income – Group Short Term	Earned Premium included in Schedule H, Part 1, Line 2, in part	_____	
a)	Earned Premium in Line (21) [up to \$50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19) + a) of Line (20)]	Company Records	_____	X 0.077 = _____
b)	Earned Premium in Line (21) not included in a) of Line (21)	Company Records	_____	X 0.046 = _____
c)	Total Disability Income – Group Short Term	a) of Line (21) + b) of Line (21), Column (2)	_____	_____

Lines (22) and (23)

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

Line (26)

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

Line (27)

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

UNDERWRITING RISK – EXPERIENCE FLUCTUATION RISK

LR017

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

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

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

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, new Lines (x.1) through (x.4) of LR019 will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future no other managed care credits are allowed for this coverage.

Claims Experience Fluctuation

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

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

or

B. An alternate risk charge that addresses the risk of catastrophic claims on any single individual. The alternate risk charge is calculated for each type of health coverage, but only the largest value is compared to the value from A. above for that type. The alternate risk charge is equal to twice a multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at two times the maximum or \$1,500,000 for Comprehensive Medical; two times the maximum or \$50,000 for each of Medicare Supplement business and \$50,000 for dental coverage and six times the maximum or \$150,000 for Medicare Part D coverage.

Line (1) through Line (18)

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

Comprehensive Medical & Hospital

Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This includes Medicare Advantage, with or without prescription drug benefits. This category DOES NOT include administrative services contracts (ASC) or administrative services only (ASO) contracts. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) business which is reported on LR018 Underwriting Risk – Other Line (3). The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000.

Medical Only (non-hospital professional services)

Include in Comprehensive Medical.

Medicare Supplement

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

Dental & Vision

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

Medicare Part D Coverage

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

Other Health Coverages

Include in the appropriate line on page LR016 Health Premiums.

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

Line (1) Premium

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

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

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

Line (2) Title XVIII Medicare

This is the earned amount of money charged by the insurer (net of reinsurance) for Medicare risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans.

Line (3) Title XIX Medicaid

This is the earned amount of money charged by the insurer for Medicaid risk business where the insurer, for a fee, agrees to cover the full medical costs of Medicaid subscribers. Revenue from Medicare Part D coverage under the low-income subsidy (cost sharing portion) and low-income subsidy (premium portion) are not included in this line.

Line (4) Other Health Risk Revenue

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

Line (5) Underwriting Risk Revenue

The sum of Lines (1.3) through (4).

Line (6) Net Incurred Claims

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

Column (1) claims come from Schedule H Part 5 Column 1 Line 13 less the amounts reported as incurred claims for Administrative Services Contracts (ASC) in Line (51) of LR026 Business Risk and Federal Employee Health Benefit Plan (FEHBP) in Line (3) of LR018 Underwriting Risk – Other. Note that Medicare supplement claims could be double counted if included in Column 1 of Schedule H Part 5 rather than Column 3. Column (2) for Medicare Supplement should be net of reinsurance, the same as the other columns. Column (2) for Medicare Supplement should use the direct claims from General Interrogatories Part 2 Line 1.5 after adjusting them for reinsurance. Column (3) dental claims come from Schedule H Part 5 Column 2 Line 13.

For Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined under the Reinsurance Payment in Appendix 3). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claim liabilities should reflect expected recoveries from the reinsurance coverage – for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS.

Line (7) Fee-for-Service Offset

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

Line (8) Underwriting Risk Incurred Claims

Line (6) minus Line (7).

Line (9) Underwriting Risk Claims Ratio

Line (8) / Line (5). If either Line (5) or Line (8) is zero or negative, Line (9) is zero.

Line (10) Underwriting Risk Factor

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

	\$0 - \$3 Million	\$3-\$25 Million	Over \$25 Million
Comprehensive Medical	0.150	0.150	0.090
Medicare Supplement	0.105	0.067	0.067
Dental	0.120	0.076	0.076
<u>Medicare Part D Coverage</u>	<u>0.141</u>	<u>0.141</u>	<u>0.109</u>

Line (11) Base Underwriting Risk RBC

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

Line (12) Managed Care Discount

For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claims payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (11) of LR019 Underwriting Risk - Managed Care Credit. An average factor based on the combined results of these three categories is used for all three.

For Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (11) of LR019 Underwriting Risk - Managed Care Credit.

Line (13) Base RBC After Managed Care Discount

Line (11) x Line (12).

Line (14) RBC Adjustment for Individual

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

Line (15) Maximum Per-Individual Risk After Reinsurance

This is the maximum loss after reinsurance for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

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

coverage maximum per claim and \$750,000 or \$25,000, whichever is applicable.

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

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

Examples of the calculation are presented below:

EXAMPLE 1 (Insurer provides Comprehensive Care):

Highest Attachment Point (Retention)	\$100,000										
Reinsurance Coverage	90% of \$500,000 in excess of \$100,000										
Maximum reinsured coverage	\$600,000 (\$100,000 + \$500,000)										
Maximum Retained Risk =	<table> <tr> <td>\$100,000</td> <td>deductible</td> </tr> <tr> <td>+ \$150,000</td> <td>(\$750,000 - \$600,000)</td> </tr> <tr> <td>+ \$50,000</td> <td>(10% of \$500,000 coverage layer)</td> </tr> <tr> <td colspan="2"><hr/></td> </tr> <tr> <td>=</td> <td>\$300,000</td> </tr> </table>	\$100,000	deductible	+ \$150,000	(\$750,000 - \$600,000)	+ \$50,000	(10% of \$500,000 coverage layer)	<hr/>		=	\$300,000
\$100,000	deductible										
+ \$150,000	(\$750,000 - \$600,000)										
+ \$50,000	(10% of \$500,000 coverage layer)										
<hr/>											
=	\$300,000										

EXAMPLE 2 (Insurer provides Comprehensive Care):

Highest Attachment Point (Retention)	\$75,000										
Reinsurance Coverage	90% of \$1,000,000 in excess of \$75,000										
Maximum reinsured coverage	\$1,075,000 (\$75,000 + \$1,000,000)										
Maximum Retained Risk =	<table> <tr> <td>\$75,000</td> <td>deductible</td> </tr> <tr> <td>+ 0</td> <td>(\$750,000 - \$1,075,000)</td> </tr> <tr> <td>+ \$67,500</td> <td>(10% of \$675,000 coverage layer)</td> </tr> <tr> <td colspan="2"><hr/></td> </tr> <tr> <td>=</td> <td>\$142,500</td> </tr> </table>	\$75,000	deductible	+ 0	(\$750,000 - \$1,075,000)	+ \$67,500	(10% of \$675,000 coverage layer)	<hr/>		=	\$142,500
\$75,000	deductible										
+ 0	(\$750,000 - \$1,075,000)										
+ \$67,500	(10% of \$675,000 coverage layer)										
<hr/>											
=	\$142,500										

Line (16) Alternate Risk Charge

Twice the amount in Line (15), subject to a maximum of \$1,500,000 for comprehensive medical and \$50,000 for ~~the other lines~~ Medicare Supplement and Dental. Six times the amount in Line (15), subject to a maximum of \$150,000 for Medicare Part D Coverage.

Line (17) Net Alternate Risk Charge

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

Line (18) Net Underwriting Risk RBC

The maximum of Line (14) and Line (17).

UNDERWRITING RISK - OTHER

LR018

Lines (1) and (2)

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

Line (3)

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

Lines (4) through (6)

Separate risk factors have been established for Workers Compensation Carve-Out business. The RBC factors for the Workers' Compensation Carve-Out will be phased in over three years in even increments beginning in 2004 and concluding in 2006. A factor of 0.364 (0.243 for 2005) is applied against net premiums written as shown in the Workers Compensation Carve-Out Supplement. A factor of 0.347 (0.231 for 2005) is applied against total net losses and expenses unpaid as shown in Schedule P, Part 1 of the Workers Compensation Carve-Out Supplement. These factors are taken from the industry component used in the P&C RBC formula for workers compensation reinsurance assumed.

A factor of 0.060 (0.040 for 2005) is applied against reinsurance recoverable balances on reinsurance ceded to non-affiliated companies (except certain pools), as shown in Schedule F, Part 2 of the Workers Compensation Carve-Out Supplement. This factor represents the difference between the total charge for reinsurance recoverables in the P&C RBC formula and the effective post-tax factor already reflected in the Life & Health formula on page LR014 Reinsurance. The following types of cessions are exempt from this charge: cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs, cessions to qualifying Voluntary Market Mechanism Pools and Associations (where there is joint liability for pool members along with adequate spread of risk, such that the risk of the pool collapsing from one or a few individual member solvency problems is immaterial), and cessions to U.S. Parents, Subsidiaries, and Affiliates. Qualifying Voluntary Market Mechanism Pools must be manually entered on Line (6.1) to receive the exemption.

UNDERWRITING RISK - MANAGED CARE CREDIT

LR019

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

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

There are currently five levels of managed care that are used in the RBC formulas [other than for Medicare Part D Coverage](#), although in the future as new managed care arrangements

evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

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

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

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

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

Line (1)

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

- Fee for service (charges).
- Discounted fee for service (based upon charges).
- Usual Customary and Reasonable (UCR) Schedules.
- Relative Value Scales (RVS) where neither payment base nor RV factor is fixed by contract or where they are fixed by contract for one year or less.
- Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding retroactive withholds later released to the provider and retroactive payments made solely because of a correction to the number of members within the capitated agreement).
- Capitation paid to providers or intermediaries that have received retroactive payments for previous years (including bonus arrangements on capitation programs).
- Claim payments not included in other categories.

Line (2)

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

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

Line (3)

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

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

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

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

[†] These are amounts due before deducting withhold or paying bonuses

[‡] These are actual payments made after deducting withhold or paying bonuses

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

Line (4)

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

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

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

Line (5)

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

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

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

Line (6)

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

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

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

Line (7)

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

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

Enter the amount of medical expense capitations paid to non-regulated intermediaries which are not affiliated with the reporting company. Do not include the amount of medical expense capitations paid to non-regulated intermediaries that are affiliated with the reporting company. These amounts should be reported in Category 0. Non-regulated intermediaries are those organizations which meet the definition in Appendix 2 for Intermediary but not Regulated Intermediary. In those cases where the capitated non-regulated intermediary (even if affiliated) employs providers and pays them non-contingent salaries or otherwise qualifies for Category 4, the insurer may include that portion of such capitated payments in Category 4.

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

Line (8)

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

- Non-contingent salaries to persons directly providing care.

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

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

Line (x.1)

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

Line (x.2)

Category 1 for Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (x.3)

Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (x.4)

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

Line (9)

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

Line (10)

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

Line (11)

Weighted Average Managed Care Risk Adjustment Factor – ~~This~~ these are ~~is~~ the credit factors ~~s~~ that ~~is~~ are carried back to the underwriting risk calculation. ~~It is~~ They are one minus the Weighted Average Managed Care Discount (Line (10)).

Lines (12) through (18)

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

Line (12)

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

Line (13)

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

Line (14)

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

Line (15)

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

Line (16)

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

Line (17)

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

Line (18)

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

LONG-TERM CARE

LR020

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

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

PREMIUM STABILIZATION RESERVES

LR023

Basis of Factors

Premium stabilization reserves are funds held by the company in order to stabilize the premium a group policyholder must pay from year to year. Usually experience rating refunds are accumulated in such a reserve so that they can be drawn upon in the event of poor future experience. This reduces the insurers risk. Amounts held as prepayments from the federal government for reinsurance coverage or low-income subsidy (cost-sharing portion) under Medicare Part D Coverage are not considered premium stabilization reserves as they relate to an uninsured plan.

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

Specific Instructions for Application of the Formula

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

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

HEALTH CREDIT RISK

LR025

Basis of Factors

The Health Credit Risk is an offset to some portions of the managed care discount factor. Since the managed care discount factor assumes that health risks are transferred to health care providers through fixed prepaid amounts, the Health Credit Risk compares these capitation payments to security the company holds. To the extent that the security does not completely cover the credit risk of capitated payments, a risk charge is applied to the exposed portion. There is no credit risk for any portion of the managed care discount factor for Medicare Part D Coverage.

Capitations – Line (1) through Line (6)

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

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

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

Specific Instructions for Application of the Formula

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

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

Line (2) - Less Secured Capitations to Providers.

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

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

Line (1) minus Line (2).

Line (4) - Total Capitations to Intermediaries.

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

Line (5) - Less Secured Capitations to Intermediaries.

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

(Figure 10)

Capitations Paid Directly to Providers

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

(Figure 11)

Capitations Paid to Non-regulated Intermediaries

Number	Name of Provider	(A)	(B)	(C)	(D)	(E)
		Paid Capitations During Year	Letter of Credit Amount	Funds Withheld	=(B+C)/A Protection Percentage	=A*Min(1,D/16%) Exempt Capitations
1	Mercy Hospital	2,500,000	200,000	300,000	20%	2,500,000
2	General	1,000,000	100,000	0	10%	625,000
3	Physicians Clinic	4,500,000	0	500,000	11%	3,125,000
4	Joe's HMO	3,500,000	0	0	0%	0
5	All others	2,500,000				0
2999999	Total to Unregulated Intermediaries	14,000,000	xxx	xxx	xxx	6,250,000

(Figure 12)

Capitations Paid to Regulated Intermediaries

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

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

The "Exempt Capitation" amount from Line 1999999 of \$800,000 would be reported on Line (2) "Less Secured Capitations to Providers" in LR025 Health Credit Risk. The total of the "Exempt Capitation" amount from Line 2999999 plus Line 3999999 (\$6,250,000+\$2,550,000=\$8,800,000) would be reported on Line (5) "Less Secured Capitations to Intermediaries" in LR025 Health Credit Risk.

BUSINESS RISK

LR026

Basis of Factors

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

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

A smaller pre-tax factor of 0.77 percent is applied against Schedule T accident and health premiums. The smaller factor for accident and health business recognizes that general business risk exposure is, in part, a function of reserves. Since life and annuity business typically carries higher

reserves than accident and health business, a lower factor is used to achieve the same relative risk coverage as for life and annuity business.

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

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

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

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

Specific Instructions for Application of the Formula

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

Appendix 2 - Commonly Used Health Insurance Terms

The DEFINITIONS OF COMMONLY USED TERMS section are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.

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

Administrative Services Contract (ASC) - A contract where the insurer agrees to provide administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. The administrator may arrange for provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self insured) bears all of the insurance risk, and there is not possibility of loss or liability to the administrator caused by claims incurred related to the plan. Claims are paid from the reporting entity's own bank accounts, and only subsequently receives reimbursement from the uninsured plan sponsor.

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

Administrative Services Only (ASO) - A contract where the insurer agrees to provide administrative services such as claims processing for a third party that is at risk, and accordingly, the administrator has not issued an insurance policy, regardless of whether an identification card is issued. The administrator may arrange for provision of medical services through a contracted or employed provider network. The plan (whether insured by another reporting entity or self insured) bears all of the insurance risk, and there is not possibility of loss or liability to the administrator caused by claims incurred related to the plan. Claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, but only after the reporting entity has received funds from the uninsured plan sponsor that are adequate to fully cover the claim payments.

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

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

Intermediary - An Intermediary is a person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for an insurer and its enrollees via a separate contract between the intermediary and the insurer.

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

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

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

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

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

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

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

Risk Revenue - Amounts charged by the reporting insurer as a provider or intermediary for specified medical services provided to the policyholders or members of another insurer or MCO. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or MCO to the reporting company in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation at the same factor as premiums and are subject to the same managed care credit categories. *NOTE: RISK REVENUE IS VERY SIMILAR TO REINSURANCE ASSUMED.*

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

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

Appendix 3 – Commonly Used Terms for Medicare Part D Coverage

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

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

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

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

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

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

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

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

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

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

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

again does not pass through the PDP Sponsor's income statement.

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

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

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

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

UNDERWRITING RISK – XR011

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

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

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

Claims Experience Fluctuation

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

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

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to ~~twice a multiple of~~ the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at \$750,000 [per individual and \\$1,500,000 total](#) for medical coverage; ~~\$375,000 for non-hospital (inpatient charges and outpatient facilities charges) provider services only business; and~~ \$25,000 [per individual and \\$50,000 total](#) for all other coverage [except Medicare Part D coverage and \\$25,000 per individual and \\$150,000 total for Medicare Part D coverage.](#) Additionally, for multiline organizations (e.g., i.e., writing ~~both medical and dental~~ [more than one coverage type](#)), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of \$~~1,50~~750,000) and dental (with a cap of \$~~250~~0,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

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

L(1) through L(18)

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

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

Comprehensive Medical & Hospital. Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are handled in Line 21 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

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

Dental. ~~This is limited to these are premiums for~~ policies providing for dental only coverage issued as stand alone dental or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

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

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

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

Line (1) Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Neither does it include federal employees health benefit programs (FEHBP). Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Line 1+ 2 of the annual statement. For Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion) which are considered funds received for uninsured plans in accordance with EAIWG Int. No. 05-05. -Beneficiary premium (supplemental benefit portion) is reported as separate premium in Line 22.x of XR013.

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

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

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

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

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

Line (5) Underwriting Risk Revenue. The sum of Lines (1) through (4).

Line (6) Net Incurred Claims. Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) claims. These amounts are found Page 7, Line 17 of the annual statement.

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

Line (7) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g. fees from non member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

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

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

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

	\$0 - \$3 Million	\$3-\$25 Million	Over \$25 Million
Comprehensive Medical	0.150	0.150	0.090
Medical Only	0.150	0.150	0.090
Medicare Supplement	0.105	0.067	0.067
Dental	0.120	0.076	0.076
<u>Medicare Part D Coverage</u>	<u>0.141</u>	<u>0.141</u>	<u>0.109</u>
Other	0.130	0.130	0.130

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

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

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

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

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

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

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

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

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

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

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

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

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

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

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

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

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

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

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

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

Line (22.x) Supplemental benefits within Medicare Part D coverage. A separate risk factor has been established to recognize the different risk (as described in Appendix 32) for the additional premium collected from beneficiaries for these supplemental drug benefits.

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

Lines (30) through (37) Long Term Care. Long Term Care Insurance (LTCI) Premiums are used to determine both a rate risk and the morbidity risk. The rate risk relates to all Noncancellable LTCI premiums. The morbidity risk is partially applied directly to premium with a higher factor (10%) applied to amounts up to \$50,000,000 and a lower factor (3%) applied to premiums in excess of \$50, 000,000. In addition, the earned premiums and incurred claims for the last two years are used to determine an average loss ratio (incurred claims divided by earned premiums). This average loss ratio times the current year's premium is called Adjusted LTCI Claims for RBC. A higher factor (25%) is applied to claims up to \$35,000,000 and a lower factor (8%) is applied to claims above \$35,000,000. In certain situation where loss ratios cannot be used because one of the values is zero or negative, the current year's incurred claims are used. In a situation where the current year's premium is not positive, higher factors are applied to current year's incurred claims to reflect the lack of a premium-based RBC. The RBC for LTCI is the sum of these three calculations.

Line (39) Limited Benefit Plans. There is a factor for certain types of Limited Benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium

on such insurance (3.5 percent) and a flat dollar amount (\$50,000) to reflect the higher variability of small amounts of business.

Line (40) Accidental Death and Dismemberment. There is a factor for Accidental Death and Dismemberment (AD&D) insurance (where a single lump sum is paid) which depends on several items:

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

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

Line (41) Other Accident. There is a factor for Other Accident – coverage that provides for any accident-based contingency other than those contained in Line 30. For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

Line (42) Premium Stabilization Reserves. Premium stabilization reserves are funds held by the company in order to stabilize the premium a group policyholder must pay from year to year. Usually experience-rating refunds are accumulated in such a reserve so that they can be drawn upon in the event of poor future experience. This reduces the insurers risk.

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

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

No credit is given here for premium stabilization reserves held for FEHBP and TRICARE coverage, because that coverage is already subject to a lesser percentage of premium in the underwriting risk calculation to reflect its reduced level of risk. Amounts held as prepayments from the federal government for reinsurance coverage or low-income subsidy (cost-sharing portion) under Medicare Part D Coverage are not considered premium stabilization reserves as they relate to an uninsured plan.

UNDERWRITING RISK - MANAGED CARE CREDIT – XR016

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXAMPLE - 2003 Reporting Year	
2002 withhold / bonus payments	750,000
2002 withholds / bonuses available	1,000,000
A. MCC Factor Multiplier	75% - Eligible for credit
2002 withholds / bonuses available	1,000,000
2002 claims subject to withhold - gross*	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B).....	15%

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

* **These are amounts due before deducting withhold or paying bonuses**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line (9) Total Paid Claims. The total of ~~Column 2~~ paid claims for Comprehensive Medical, Medicare Supplement and Dental. [should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement less line (8.3).?]]

Line (x.1)

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

Line (x.2)

Category 1 for Medicare Part D Coverage would be for all claims during a period when only the reinsurance coverage is provided. This is designed for some future time period and is not to be interpreted as including employer-based Part D coverage that is not subject to risk corridor protection.

Line (x.3)

Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (x.4)

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

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

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

Line (11) - Weighted Average Managed Care Risk Adjustment Factor. ~~These~~~~s~~ ~~are~~~~s~~ the credit factor~~s~~ that ~~are~~~~s~~ carried back to the underwriting risk calculation. ~~It is~~They are one minus the Weighted Average Managed Care Discount values in (~~Line 10~~).

Lines (12) through (18) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses. This table requires data from the PRIOR YEAR to compute the current year's discount factor. These do not apply to Medicare Part D coverage.

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

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

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

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

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

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

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

CREDIT RISK XR018

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

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

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

Capitations - L(18) through L(24)

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

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

The credit risk RBC requirement for capitations to intermediaries is 4 percent of the annual statement amount of the capitated payments reported as paid claims in the Managed Care Credit Calculation page. However, as with capitations paid directly to providers, the regulated MCO can eliminate some or all of the credit risk that arises from capitations to intermediaries by obtaining acceptable letters of credit or withheld funds. [There is no credit risk for any portion of the managed care discount factor for Medicare Part D Coverage.](#)

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

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

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

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

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

**CAPITATIONS TO PROVIDERS AND INTERMEDIARIES
CREDIT RISK EXEMPTION WORKSHEET**

CAPITATIONS PAID DIRECTLY TO PROVIDERS

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

CAPITATIONS PAID TO UNREGULATED INTERMEDIARIES

		A	B	C	D=(B+C)/ A	E=A*Min(1,D/1 6%)
Number	Name of Provider	Paid Capitations During Year	Letter of Credit Amount	Funds Withheld	Protection Percentage	Exempt Capitations
1	Mercy Hospital	2,500,000	200,000	300,000	20%	2,500,000
2	Chicago Hope	1,000,000	100,000	0	10%	625,000
3	Bill's Clinic	4,500,000	0	500,000	11%	3,125,000
4	Joe's HMO	3,500,000	0	0	0%	0
5	All others	2,500,000				0
29999	Total to Unregulated Intermed	14,000,000	xxx	Xxx	xxx	6,250,000

CAPITATIONS PAID TO REGULATED INTERMEDIARIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BUSINESS RISK – XR020

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

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

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

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

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

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

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

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

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

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

The RBC requirement for administrative expenses on non-underwritten and limited risk business is 2 percent of both ASC administrative expense and ASO administrative expenses. The RBC requirement for claims payments paid through ASC arrangements is 1 percent of the medical expense payments (not including Medicare Part D payments under the reinsurance payment or low-income subsidy (cost sharing portion)).

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

Guaranty Fund Assessment Risk - L(12)

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

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

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

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

To calculate excessive growth risk RBC in future years, enter prior year's underwriting risk revenue [Prior Year Underwriting Risk – Experience Fluctuation Risk page, Column (6), Line (5)] in Line (13). The current year's underwriting risk revenue is automatically imported to Line (14) from this year's table. The prior year's Net Underwriting Risk RBC [Prior Year Underwriting Risk – Experience Fluctuation Risk page, C(6), L(18)] is entered on Line (15) and the current year value is pulled automatically into Line (16). The growth rate in underwriting risk revenue plus 10 percent is multiplied times the prior year's Net Underwriting Risk RBC in Line (15) to establish the safe harbor level for the current year. For 2006, these calculations will exclude the premiums and Net Underwriting Risk RBC applicable to Medicare Part D coverage as this line of business did not exist prior to January 1, 2006.

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

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

APPENDIX 1 - COMMONLY USED TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

Intermediary - A person, corporation or other business entity (not licensed as a medical provider) that arranges, by contracts with physicians and other licensed medical providers, to deliver health services for a reporting entity and its enrollees via a separate contract between the intermediary and the reporting entity.

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

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

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

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

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

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

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

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

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

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

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

Risk Revenue - Amounts charged by the reporting entity as a provider or intermediary for specified medical services provided to the policyholders or members of another insurer or MCO. Unlike premiums, which are

collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or MCO to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation at the same factor as premiums and are subject to the same managed care credit categories. *NOTE: RISK REVENUE IS VERY SIMILAR TO REINSURANCE ASSUMED.*

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

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

APPENDIX 2 – COMMONLY USED TERMS FOR MEDICARE PART D COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B:
RBC Opinion Survey on Medicare Part D.



AMERICAN ACADEMY *of* ACTUARIES

October 2005

RBC Opinion Survey on Medicare Part D

Medicare Part D will be available to Medicare beneficiaries beginning January 1, 2006. The current NAIC Risk-Based Capital (RBC) Model does not have underwriting risk factors that are appropriate for this new Medicare pharmacy coverage. Therefore, the NAIC Capital Adequacy Task Force has asked the American Academy of Actuaries'¹ RBC Work Group on Medicare Part D to develop recommendations for new RBC factors, for both the Health and Life RBC formulas, to apply to Part D.

The Purpose of This Survey

In previous Academy recommendations to the NAIC for appropriate RBC underwriting risk factors for health coverage, the Academy's Task Force on Health RBC was able to gather large volumes of relatively homogeneous loss ratio experience for specified categories of health coverage. Many years of experience data were gathered from a broad cross-section of contributing companies from the life and health insurance industries. The data was analyzed using rigorous statistical modeling techniques in order to develop estimates of required minimum capital levels for these coverage categories at appropriate levels of confidence of ruin avoidance. However, we do not have the same wealth of historical pharmacy experience data for a Medicare population.

Since the necessary data is not available at this point in time to perform statistical modeling studies to develop minimum capital requirements for Part D, such a study will be deferred until sufficient experience data can be collected over the next several years. For our current project, we will instead use actuarial judgment considering the opinions received from actuaries through this survey, the range of RBC factors for specified categories of health coverage in the current NAIC Model, and the risk reduction features in the Part D Program in developing our RBC factor recommendation for this new coverage. We are confident in using this method as it has previously been used in the development of the underwriting risk factor recommendation for "Other Health" in the current RBC Model. That risk factor recommendation was also developed using actuarial judgment and considering the relative levels of the other factors that had been statistically derived for the other coverage categories specified in the Model.

¹ The American Academy of Actuaries is the public policy organization for 14,000 actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the actuarial profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also supports the development and enforcement of actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

Your input is vital to the success of this effort. You have been selected to take part in this short *and extremely important* survey due to your relevant knowledge of Part D and its pricing, as well as health insurance business in general. We would greatly appreciate your participation and welcome whatever input you can provide to our Work Group. If you feel that it would be more appropriate for someone else in your company or a consultant to your company to respond to the survey, please forward this information to that individual. In order to avoid duplication, we are limiting each company to a single response. An Academy staff member will be following up on this written request. The NAIC has requested the results of this survey prior to the scheduled Winter Meeting in December 2005. Therefore, we ask that you respond to this survey by **Wednesday, November 2, 2005**. We appreciate your understanding of this tight timeline and thank you in advance for your participation.

Recognizing the sensitive nature of this information, all studies will be regarded as confidential. Your answers will be seen only by Academy staff and individual results by company will not be available to the Work Group. Data will not be used by any single company within the Work Group for purposes other than those of the Work Group as a whole. Any results presented in the final report will be summarized across contributing companies to ensure that all information is protected.

Background

Note: A summary of some key features of the new Part D coverage, including its risk reduction features, is included in a second attachment to this mailing.

In establishing the RBC levels for this new coverage, we must consider at least three important risk reduction features that significantly reduce risk for a life or health insurance company. These are:

- Federal reinsurance coverage of 80% of the catastrophic risk above \$5,100 of annual pharmacy claims cost per individual (“reinsurance subsidy”);
- Federal risk corridor protection for the portion of the standard (or actuarially equivalent) pharmacy benefit costs underwritten by the insurer; and
- Revenue that will be risk adjusted for the health status profile of the population insured by the carrier.

The current NAIC Health RBC Model would result in a RBC requirement for the underwriting risk factor at a level 13% of annual incurred claims, since stand-alone prescription drug coverage falls into the “Other Health” category of medical insurance within the NAIC Health RBC Model Law. However, this 13% factor does not take into account any of the above risk reduction mechanisms built into the Part D Program.

There are minor differences in the RBC factors in the case of a life insurance company. For example, there is a 12% factor applied to the premium for the “Other Health” category instead of 13% of incurred claims. However, consideration of these differences is not material to our discussion of the relative range of the current RBC factors below, when compared to the 13% of incurred claims or 12% of premium for “Other Health.” Rather, the point to be made is that the “Other Health” factor

included in both RBC models is intended to apply to miscellaneous other health coverage such as stand-alone pharmacy and any other health coverage not separately addressed by the formula.

As a point of reference, the following shows the underwriting risk factors currently applied to incurred claims for the specified categories of medical insurance coverage listed in the HRBC Model:

- Comprehensive Major Medical—15% of the first \$25 million and 9% thereafter. In addition, Managed Care Credits apply to these percentages that can range from 0% to 75%. For example, the credit applied for fully capitated medical costs is 60%. This would reduce the above 15% to 6% and the 9% to 3.6%.
- Medicare Supplement—10.5% of the first \$3 million and 6.7% thereafter.
- Dental and Vision—12% of the first \$3 million and 7.6% thereafter.
- Federal Employee Health Benefit Plan (FEHBP) and the TriCare Program—2% of incurred claims to recognize the reduced risks associated with these programs as a result of the government risk sharing built into these programs.

For the moment, if one accepts that it is appropriate to apply the 13% underwriting risk factor to stand-alone pharmacy coverage that does **not** contain any of the risk reduction features listed above, it is clear that it would not be appropriate to apply this same factor to Part D coverage, which does have these features.

The Survey

At this pre-data point in time, we plan to develop only new factors for fully insured, stand-alone Part D coverage for standard or actuarially equivalent coverage and the Reinsurance Payment Demonstration coverage. We will recommend that the current “Other Health” factor of 13% for Health RBC, and the corresponding Life RBC factor, continue to apply for the supplemental benefit portion of coverage, since this is not subject to any risk reduction from the government. Also, we will not be recommending any change for combined Medicare Advantage and Part D coverage. That is, the 15% and 9% factors will continue to hold for both the medical and pharmacy portions of this combined coverage. In the future, when experience data is available, our recommendation can be further refined. If you are not able to completely answer all of the questions below, please provide responses to those questions, or portions of questions, that you are able to answer.

Please provide your opinions for the following eight questions:

1. Assume that a carrier has filed a bid with CMS with a target benefit ratio (i.e. loss ratio) of X. What would you consider to be reasonably worst case (95% confidence level) and moderately adverse case (70% confidence level) scenarios for the experience expressed as a percent of X (not of premium)? That is, an answer of 150% of X would mean that actual ultimate claims costs would be 50% greater than the pricing actuaries had assumed in their pricing. In answering this question, assume that revenue is not risk adjusted for health status and that there is no risk corridor protection. Also assume that the carrier does not participate in the Reinsurance Payment Demonstration and receives the average premium calculated in the pricing of the product and filed with CMS for standard (or actuarially equivalent) coverage.
 - a. Reasonably worst case scenario: _____
 - b. Moderately adverse case scenario: _____

2. What would your answers to Question #1 be if you also consider that CMS will use health status risk adjustment to adjust revenue to account for the risk profile of the actual enrolled population (but still ignore risk corridors)?
 - a. Reasonably worst case scenario: _____
 - b. Moderately adverse case scenario: _____

3. Would your answer to Question #1 change for Plans that participate in the Reinsurance Payment Demonstration? That is, the applicable fully insured coverage includes both the standard (or actuarially equivalent) benefit and the additional 80% of catastrophic claims in excess of \$5,100 per individual per year. If so, please provide your new response below. In answering this question, again assume that revenue is not risk adjusted for health status and that there is no risk corridor protection. Also assume that the carrier receives the average premium calculated in the pricing of the catastrophic coverage for the Reinsurance Payment Demonstration and the average premium calculated in the pricing of the product and filed with CMS for standard (or actuarially equivalent) coverage.
 - a. Reasonably worst case scenario: _____
 - b. Moderately adverse case scenario: _____

4. What would your answers to Question #3 be if you also consider that CMS will use health status risk adjustment to adjust revenue to account for the risk profile of the actual enrolled population (but still ignore risk corridors)?
 - a. Reasonably worst case scenario: _____
 - b. Moderately adverse case scenario: _____
5. In answering the above questions, what volume of business did you have in mind? ___ Less than \$3 million of annual premium; ___ Greater than \$3 million but less than \$25 million of premium; ___ Greater than \$25 million of premium.
6. Depending on how you answered question 5, discuss how your answers to questions 1-4 would change if you were to answer these questions for the other two specified premium volume ranges (attach answers on separate page)?
7. If you feel there should be a higher factor applied to low volumes of Part D business and a lower factor for higher volumes, where should the break point be? ___ At \$3 million; ___ At \$25 million; ___ If other, state amount.
8. In developing your company's stand-alone Part D product (i.e. PDP), what was the average profit and/or risk margin assumed in aggregate (i.e., all products and regions combined) for your bid submission.
___ Less than 2%, ___ 2-4%, ___ Greater than 4%

Title: Illustration.

General inputs:

0.0000 Minimum spread for reasonableness check: "with reinsurance" no greater than "without reinsurance" minus spread.

1.2820 Tolerance for health status risk adjustment (# of standard deviations).

Risk-corridor parameters:

1.0250 First threshold.

1.0500 Second threshold.

0.7500 First corridor risk-sharing proportion.

0.8000 Second corridor risk-sharing proportion.

0.0400 Normal pre-tax profit assumption.

0.0200 Minimum factor permitted.

Results:

Volume of business	With no risk mitigation - Scenario (a):				With no risk mitigation - Scenario (b):			
	<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Median</u>	<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Median</u>
< \$3 MM	0.3852	0.3852	0.3852	0.3852	0.5136	0.5136	0.5136	0.5136
\$3-25 MM	0.3558	0.3558	0.3558	0.3558	0.5164	0.5164	0.5164	0.5164
> \$25 MM	0.3208	0.3208	0.3208	0.3208	0.4090	0.4090	0.4090	0.4090
< \$25 MM	0.3558	0.3852	0.3748	0.3852	0.5136	0.5164	0.5146	0.5136
> \$3 MM	0.3208	0.3558	0.3339	0.3208	0.4090	0.5164	0.4493	0.4090
All	0.3208	0.3852	0.3548	0.3558	0.4090	0.5164	0.4755	0.5136
Volume of business	With Risk-Corridor Protection only - Scenario (a):				With Risk-Corridor Protection only - Scenario (b):			
	<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Median</u>	<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Median</u>
< \$3 MM	0.0663	0.0663	0.0663	0.0663	0.0492	0.0492	0.0492	0.0492
\$3-25 MM	0.0604	0.0604	0.0604	0.0604	0.0498	0.0498	0.0498	0.0498
> \$25 MM	0.0534	0.0534	0.0534	0.0534	0.0283	0.0283	0.0283	0.0283
< \$25 MM	0.0604	0.0663	0.0642	0.0663	0.0492	0.0498	0.0494	0.0492
> \$3 MM	0.0534	0.0604	0.0560	0.0534	0.0283	0.0498	0.0364	0.0283
All	0.0534	0.0663	0.0602	0.0604	0.0283	0.0498	0.0416	0.0492
Volume of business	With Reinsurance Coverage and Risk-Corridor Protection - Scenario (a):				With Reinsurance Coverage and Risk-Corridor Protection - Scenario (b):			
	<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Median</u>	<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Median</u>
< \$3 MM	0.0491	0.0491	0.0491	0.0491	0.0259	0.0259	0.0259	0.0259
\$3-25 MM	0.0371	0.0371	0.0371	0.0371	0.0297	0.0297	0.0297	0.0297
> \$25 MM	0.0383	0.0383	0.0383	0.0383	0.0220	0.0220	0.0220	0.0220
< \$25 MM	0.0371	0.0491	0.0449	0.0491	0.0259	0.0297	0.0272	0.0259
> \$3 MM	0.0371	0.0383	0.0378	0.0383	0.0220	0.0297	0.0249	0.0220
All	0.0371	0.0491	0.0424	0.0383	0.0220	0.0297	0.0253	0.0259