Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force
[ ] Catastrophe Risk (E) Subgroup
[ ] Variable Annuities Capital. & Reserve (E/A) Subgroup
[x] Health RBC (E) Working Group
[ ] Investment RBC (E) Working Group
[ ] P/C RBC (E) Working Group
[ ] Life RBC (E) Working Group
[ ] Longevity Risk (A/E) Subgroup
[ ] RBC Investment Risk & Evaluation (E) Working Group

DATE: 8-19-22	**FOR NAIC USE ONLY**
CONTACT PERSON: Crystal Brown	Agenda Item # 2022-11-H
TELEPHONE: 816-783-8146	Year 2023
EMAIL ADDRESS: cbrown@naic.org	**DISPOSITION**
ON BEHALF OF: Health Risk-Based Capital (E) Working Grp	[x] ADOPTED WG 12/12/22 & TF 12/14/22
NAME: Steve Drutz	[ ] REJECTED
TITLE: Chief Financial Analyst/Chair	[ ] DEFERRED TO
AFFILIATION: WA Office of Insurance Commissioner	[ ] REFERRED TO OTHER NAIC GROUP
ADDRESS: 5000 Capitol Blvd SE	[x] EXPOSED WG 9/9/22
Tumwater, WA 98501	[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[x] Health RBC Blanks [ ] Property/Casualty RBC Blanks [ ] Life and Fraternal RBC Instructions
[x] Health RBC Instructions [ ] Property/Casualty RBC Instructions [ ] Life and Fraternal RBC Blanks
[ ] OTHER _____

DESCRIPTION OF CHANGE(S)

Update the annual statement source descriptions and align the lines of business to the changes in the Analysis of Operations based on Blanks proposal 2021-17BWGMOD on page XR013, XR014.

REASON OR JUSTIFICATION FOR CHANGE **

Align the Health RBC formula with Annual Statement changes to the Analysis of Operations.

Additional Staff Comments:

9-9-22 cgb HRBCWG exposed for 30 day comment period
12-12-22 cgb No comments received during comment period. WG adopted at Fall National Meeting
12-14-22 cgb Capital Adequacy (E) Task Force adopted at Fall National Meeting.

**** This section must be completed on all forms.** **Revised 7-2022**

UNDERWRITING RISK - L(1) THROUGH L(21)
XR013

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 comes 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. Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for 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 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; $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 multi-line organizations (e.g., writing 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 (hospital & medical) individual & group (with a cap of $1,500,000) and dental (with a cap of $50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

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

credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports, the RBC results for all of the formula components shall be calculated using actual data.

L(1) through L(21)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive ~~Medical and (~~Hospital & Medical) individual & group; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; and (5) Other Health; and (6) Other Non-Health. 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:

Column (1) – Comprehensive ~~Medical & (~~Hospital & Medical) Individual & Group. 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 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 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.

Column (2) – 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 & medical) individual & group.

Column (3) – Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

Column (4) – Stand-Alone 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 INT 05-05: Accounting for Revenue under Medicare Part D Coverage 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 on page XR015. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

Column (5) – Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, **NOT INCLUDED ABOVE** that have not been specifically addressed in the other columns listed above.

Column (6) – Other Non-Health Coverages. This includes life and property and casualty coverages.

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. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. 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, Lines 1 and 2 of the annual statement. For Stand-Alone 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 INT 05-05: Accounting for Revenue under Medicare Part D Coverage 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 Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage.

> **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, Lines 1 and 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, Lines 1 and 2 of the annual statement. Stand-Alone 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 health entity. 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 health entity 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) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

Line (6) Underwriting Risk Revenue. The sum of Lines (1) through (4) minus Line (5).

Line (7) 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) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims 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. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR015.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims. Line (7) minus Line (8).

Line (10) 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 (11) Underwriting Risk Incurred Claims. Line (9) minus Line (10).

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 0.5%.

	$0 – $3 Million	$3 – $25 Million	Over $25 Million
Comprehensive ~~Medical & (~~Hospital & Medical) Individual & group	0.1493	0.1493	0.0893
Medicare Supplement	0.1043	0.0663	0.0663
Dental & Vision	0.1195	0.0755	0.0755
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive ~~Medical & (~~Hospital & Medical) individual & group, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive ~~Medical & (~~Hospital & Medical) individual & group, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) 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 Stand-Alone 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 (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount. Line (14) x Line (15).

Line (17) 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, 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 (18) Alternate Risk Charge. This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.

Line (19) Alternate Risk Adjustment. This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (20) Net Alternate Risk Charge. This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

Line (21) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

OTHER UNDERWRITING RISK – L(22) THROUGH L(45)

XR015–XR017

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 (Hospital & Medical) individual & group, Medicare Supplement, Dental/Vision, Stand-Alone 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 two percent to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive (Hospital & Medical) individual & group. It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive (Hospital & Medical) individual & group. A factor of 35 percent will be applied to the first $25,000,000 in premium and a factor of 25 percent will be applied to premium in excess of $25,000,000.

Line (25.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in INT 05-05: Accounting for Revenue under Medicare Part D Coverage) for the incurred claims associated with the beneficiaries for these supplemental drug benefits.

Line (25.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital Working Group however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2 percent factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR013, Column (1), Line (5).

Lines (26) through (32) 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 are combined**.** All types of Group and Credit Disability Income are combined in a different category from Individual.

UNDERWRITING RISK

Experience Fluctuation Risk

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual & Group	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1) †	Premium							
(2) †	Title XVIII-Medicare		XXX	XXX	XXX	XXX	XXX	
(3) †	Title XIX-Medicaid		XXX	XXX	XXX	XXX	XXX	
(4) †	Other Health Risk Revenue		XXX				XXX	
(5)	Medicaid Pass-Through Payments Reported as Premiums		XXX	XXX	XXX	XXX	XXX	
(6)	Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)							
(7) †	Net Incurred Claims						XXX	
(8)	Medicaid Pass-Through Payments Reported as Claims		XXX	XXX	XXX	XXX	XXX	
(9)	Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)						XXX	
(10) †	Fee-For-Service Offset		XXX				XXX	
(11)	Underwriting Risk Incurred Claims = Lines (9) - (10)						XXX	
(12)	Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)						1.000	XXX
(13)	Underwriting Risk Factor*					0.130	0.130	XXX
(14)	Base Underwriting Risk RBC = Lines (6) x (12) x (13)							
(15)	Managed Care Discount Factor						XXX	XXX
(16)	RBC After Managed Care Discount = Lines (14) x (15)						XXX	
(17) †	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(18)	Alternate Risk Charge **						XXX	XXX
(19)	Alternate Risk Adjustment						XXX	XXX
(20)	Net Alternate Risk Charge***						XXX	
(21)	Net Underwriting Risk RBC (MAX{Line (16), Line (20)}) for Columns (1) through (5), Column (6), Line (14)							

TIERED RBC FACTORS*						
	Comprehensive (Hospital & Medical) - Individual & Group	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$0 - $3 Million	0.1493	0.1043	0.1195	0.251	0.130	0.130
$3 - $25 Million	0.1493	0.0663	0.0755	0.251	0.130	0.130
Over $25 Million	0.0893	0.0663	0.0755	0.151	0.130	0.130

ALTERNATE RISK CHARGE**						
** The Line (15) Alternate Risk Charge is calculated as follows:						
LESSER OF:	$1,500,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$150,000 or 6 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

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

*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.

† Annual Statement Source

	Line of Business	(1) Comprehensive (Hospital & Medical) - Individual & Group	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1)	Premium	Page 7, Columns 2 & 3, Lines 1 + 2	Page 7, Column 4, Line 1 + 2	Page 7, Columns 5 & 6, Line 1 + 2			Page 7, Column 14, Lines 1 + 2	
(2)	Title XVIII-Medicare	Page 7, Column 8, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 7, Lines 1 + 2
(3)	Title XIX-Medicaid	Page 7, Column 9, Lines 1 + 2	XXX	XXX	XXX	XXX	XXX	Page 7, Column 8, Lines 1 + 2
(4)	Other Health Risk Revenue	Page 7, Columns 2 & 3, Line 4	XXX	Page 7, Columns 5 & 6, Line 4			XXX	
(7)	Net Incurred Claims	Page 7, Columns 2 + 3 + 7 + 8, Line 17	Page 7, Column 4, Line 17	Page 7, Columns 5 & 6, Line 17			XXX	
(10)	Fee-For-Service Offset	Page 7, Columns 2 & 3, Line 3	XXX	Page 7, Columns 5 & 6 , Line 3			XXX	
(17)	Maximum Per-Individual Risk After Reinsurance	Gen Int Part 2 Lines 5.31 + 5.32	Gen Int Part 2 Line 5.33	Gen Int Part 2 Line 5.34			XXX	XXX

Denotes items that must be manually entered on filing software.

Limited Benefit Plans (Individual and Group Combined)		Annual Statement Source	(1) Amount	Factor		(2) RBC Requirement
(42)	Hospital Indemnity and Specified Disease	Included in Page 7, Column 13, Line 1 and 2, in part		0.035		
(42.1)	$50,000 if Line (42) is Greater Than Zero					
(42.2)	Total Hospital Indemnity and Specified Disease	Lines (42) + (42.1)				
(43)	Accidental Death & Dismemberment	Included in Page 7, Column 13, Line 1 and 2, in part				
(43.1)	First $10 Million Earned Premium of Line (43)			0.055		
(43.2)	Over $10 Million Earned Premium of Line (43)			0.015		
(43.3)	Maximum Retained Risk for Any Single Claim	Company Records				
(43.4)	Three Times Line (43.3)					
(43.5)	Lesser of Line (43.4) or $300,000					
(43.6)	Total AD&D	Lines (43.1) + (43.2) + (43.5)				
(44)	Other Accident	Included in Page 7, Column 13, Line 1 and 2, in part		0.050		
(45)	Premium Stabilization Reserves	Included in U&I, Part 2D, Column 1, Line 4		-0.500	Φ	
(46)	Total Other Underwriting Risk	Lines (25.3) + (26.3) + (27.3) + (28.3) + (29.3) + (30.6) + (31.3) + (32.3) + (41) + (42.2) + (43.6) + (44) + (45)				

Φ This is limited to the Total Net Underwriting RBC on XR013, Column (7), Line (21) Less Column (4), and XR015, Column (2), Lines (25.3), (26.3), (27.3), (28.3), (29.3), (30.6), (31.3), (32.3), XR016 Column (2), Line (36) and XR017 Column (2), Lines (42.2), (43.6), and (44).

Denotes items that must be manually entered on filing software.