**** This section must be completed on all forms.** **Revised 2-2019**

HEALTH

UNDERWRITING RISK – MANAGED CARE CREDIT
XR017

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and property/casualty 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 are:

Category 1 – Contractual Fee Payments

* Category 2 – Bonus and/or Incentives / Withhold Arrangements
* Category 3 – Capitation
* Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and

This amount should equal Exhibit 7, Part 1, Column 1, Line 15 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13)

Line (2) – Category 1 – Payments Made According to Contractual Arrangements

Line (4) – Category 2b – Payments Made Subject to Withholds or Bonuses/Incentives

either within or beyond a 12-month period, the entire arrangement shall be subject to a managed care credit

Line (17)– Weighted Average Managed Care Risk Adjustment Factors. These are

LIFE

UNDERWRITING RISK - MANAGED CARE CREDIT

LR022

This worksheet LR022 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the comprehensive medical dental business, Stand-Alone 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 completed (and then Line (9) will be required).

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between 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 those managed care arrangements that have

- Usual customary and reasonable (UCR) schedules.
- Relative value scale (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 another 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 in capitation programs).
- Claim payments not included in other categories.

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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/Incentives 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/incentives paid to providers during the prior year to total withholds and bonuses/incentives 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/incentive 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/incentive payments	750,000
1997 withholds / bonuses/incentives available	1,000,000
A . MCC Factor Multiplier	75% Eligible for credit
1997 withholds / bonuses/incentives 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 ‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses/incentives.

‡ These are actual payments made after deducting withhold or paying bonuses/incentives

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

Line (4)

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.

Weighted Average Managed Care Risk Adjustment Factor – These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (16)).

Lines (18) through (24)
Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 payments subject to withholds and bonuses/incentives. This table requires data from the PRIOR YEAR to compute the current year's discount factor.

Line (18)
Enter the prior year's actual withhold and bonus/incentive payments.

Line (19)
Enter the prior year's withholds and bonuses/incentives that were available for payment in the prior year.

Line (20)
Divides Line (18) by Line (19) to determine the portion of withholds and bonuses/incentives that were actually returned in the prior year.

Line (21)
Equal to Line (19) and is automatically pulled forward.

Line (22)
Claims payments that were subject to withholds and bonuses/incentives in the prior year. Equal to Line (3) + Line (4) of LR022 Underwriting Risk – Managed Care Credit FOR THE PRIOR YEAR.

Line (23)
Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24)
Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on performance of (e)4.2 (s)]TJ 0 0.471q6.9 ( )-2 (e)2.2 ((4)46.9 ( )-28h5c73R( )-2 (r

PR021 - Underwriting Risk – Managed Care Credit

This worksheet PR021 Underwriting Risk – Managed Care Credit is optional. It may be completed for only part of the Comprehensive Medical, Stand-Alone Medicare Part D Coverage, Dental business 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 claims. Those managed care arrangements that have the greatest reduction in the uncertainty of claims payments receive the greatest credit, while those that have little 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 Stand-Alone 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 existing categories. The managed care categories are:

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

For Stand-Alone 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, Lines (10.1) through (10.4) 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 credit is 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 – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) and 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 related non-intermediaries who are affiliated with the reporting company in order to ensure that true risk transfer is accomplished.

* Retroactive payments to capitated providers or intermediaries whether by capitation or other payment method (excluding 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.

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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 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, Bonuses, Incentives 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 withholds returned and bonuses and/or incentives paid to providers during the prior year to total withholds, bonuses and incentives 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. Bonuses and/or incentive payments that are not related to financial results are not included (e.g., patient satisfaction). Therefore, the credit factor is equal to 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‡ in the current year.

† These are amounts due before deducting withhold or paying bonuses or incentives.

‡ These are actual payments made after deducting withhold or paying bonuses or incentives.

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/Incentives 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 Category 2b managed care credit is 15 percent (Category 1 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/or 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 made 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 1 for definition). In 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 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 of Intermediary but not regulated Intermediary in Appendix 1. In 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

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 providers and intermediaries.

Line (8)
Category 4 -

Weighted Average Managed Care Risk Adjustment Factor -

HEALTH, LIFE AND PROPERTY AND CASUALTY

APPENDIX 1 – COMMONLY USED TERMS

UNDERWRITING RISK - Managed Care Credit Calculation

	(1)	(2)	(3)	(4)
		Paid	Weighted	Part D Weighted
Managed Care Claims Payments				

		(1)
	Annual Statement Source	Amount
* Calculation of Category 2 Managed Care Factor		
(18) Withhold & Bonus/Incentive Payments, Prior Year	Company Records	[redacted]
		[redacted]

[redacted]

UNDERWRITING RISK – MANAGED CARE CREDIT

Comprehensive Medical, Medicare Supplement and Dental Claim Payments	Annual Statement Source	(2) Paid Claims	Factor	(3) Weighted Claims	(4) Part D Weighted