Capital Adequacy (E) Task Force

RBC Proposal Form

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

DATE: 8-19-22

CONTACT PERSON: Crystal Brown

TELEPHONE: 816-783-8146

EMAIL ADDRESS: cbrown@naic.org

ON BEHALF OF: Health Risk-Based Capital (E) Working Grp

NAME: Steve Drutz

TITLE: Chief Financial Analyst/Chair

AFFILIATION: WA Office of Insurance Commissioner

ADDRESS: 5000 Capitol Blvd SE
Tumwater, WA 98501

[ ] DEFERRED TO _____

[ ] REFERRED TO OTHER NAIC GROUP _____

[x] EXPOSED WG 9/9/22

[ ] 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)

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 c

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)

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 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, Pages 7, Line 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.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in SSAP No. 105—Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset to 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 to be recovered 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

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 (17), Line (1) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three lines is used for all three.

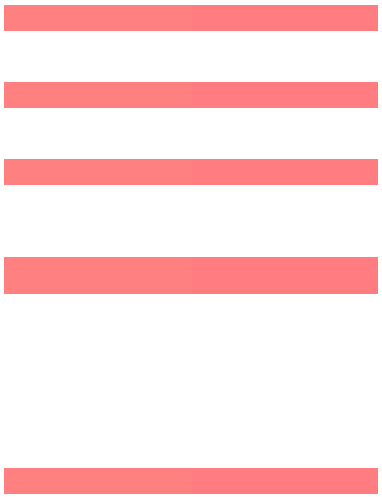
For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in the uncertainty about future claims payments attributable to the federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed 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-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 th0.5 (s)2.7 (t) (s)2f

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 loss of this 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.



† Annual Statement Source

(1)	(2)	(3)	(4)	(5)	(6)

Limited Benefit Plans (Individual and Group Combined)

	(1)	(2)
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	