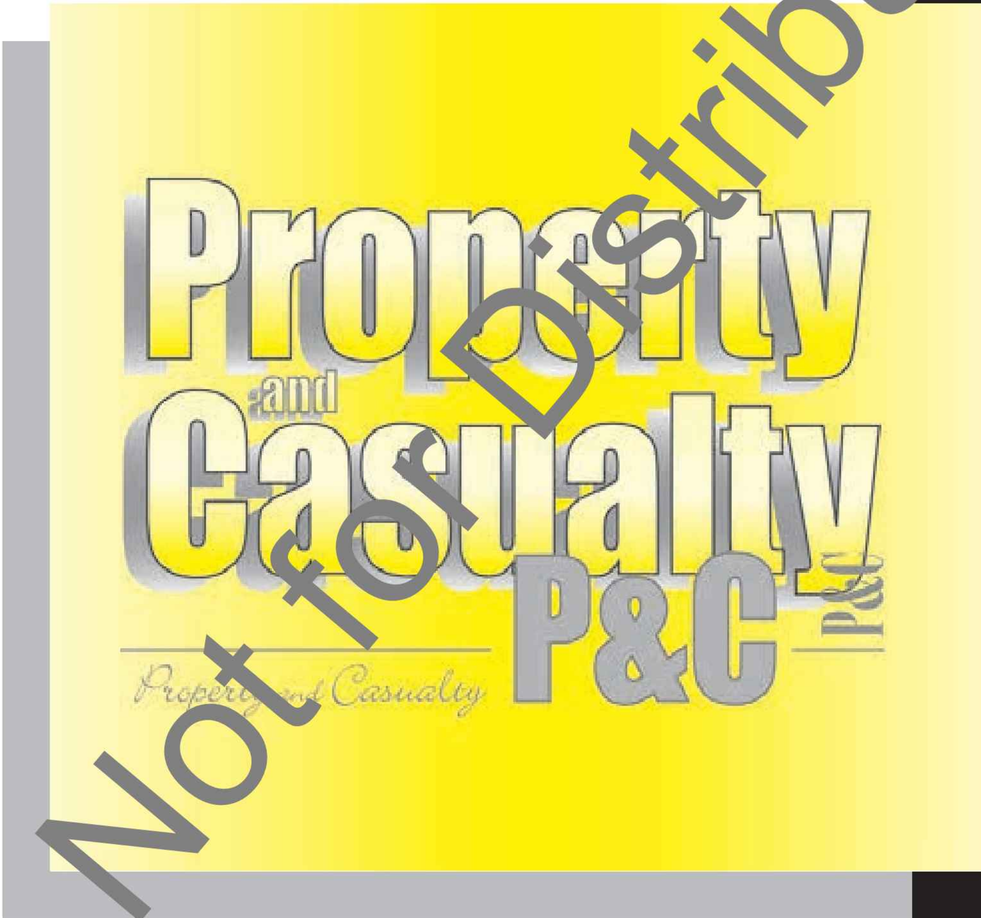
2018

RBC

Risk-Based Capital



FORECASTING

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Risk-Based Capital Forecasting & Instructions

Property/Casualty

2018

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NAIC Property and Casualty Risk-Based Capital Newsletter

August 2018

Volume 22.1

What RBC Pages Should Be Submitted?

For year-end 2018 property/casualty (P/C) risk-based capital (RBC), hard copies of pages **PR001 through PR035,** as well as **PR038 and PR039,** should be submitted to any state that requests a hard copy. Beginning with the year-end 2011 RBC, a hard copy was not required to be submitted to the NAIC, but a portable document format (PDF) file representing the hard copy filing is part of the electronic filing with the NAIC.

Affiliated Bonds

As a result of the adoption of proposal 2017-14-P by the Capital Adequacy (E) Task Force at the 2018 Spring National Meeting, the RBC charge for the affiliated bonds from PR003, PR004 and PR005 in the RBC formula were removed. Both affiliated and unaffiliated Bonds will be reported in the PR006 and PR011. Columns, Lines were eliminated and the line references were updated on PR003, PR004, PR006 and PR030 to reflect the change.

MMMFs

As a result of the adoption of proposal 2017-07-CA and proposal 2017-07-CA (MOD) by the Capital Adequacy (E) Task Force at the 2018 Spring National Meeting, the non-government MMMFs line for Common Stocks in PR007 was removed. Also, the reference for Line (18) was updated.

Receivable for Securities

As a result of the adoption of proposal 2018-09-CA by the Capital Adequacy (E) Task Force on its June 28 conference call, the factor of Line (1) Receivable for Securities of Miscellaneous Assets (PR009) and Line (25) of Asset Concentration (PR011) were updated.

Operational Risk

A revised basic operational risk "add-on" structure and instructions were adopted by the Capital Adequacy (E) Task Force during its March 25 and April 28 conference calls, respectively. The "add-on" is equal to 3% of total RBC after covariance in all RBC formulas. The operational risk charge is offset (to a minimum of zero) by the amount of C-4a risk RBC carried by life RBC filers, as well as the C-4a risk RBC of life insurance subsidiaries owned directly by any insurer type.. The basic operational risk charge will be effective with the filing of the 2018 RBC formulas. The RBC charge was previously set at 0% for 2017 RBC by the Task Force based on a technical issue that was subsequently addressed by the Operational Risk (E) Subgroup.

In This Issue:

What RBC Pages to Submit 1
Affiliated Bonds 1
MMMFs 1
Receivable for Securities 1
Operational Risk 1
Credit Risk 2
Catastrophe Risk 2
Stop Loss Interrogatories 2
Medicaid Pass-Through Payments 2
Federal ACA Changes 2
App. 2—Commonly Used Terms for Med Pt D Cov... 2
Industry Average Risk Factors 3
RBC Forecasting & Instructions 4

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Credit Risk

As a result of the changed in the Annual Statement, Schedule F, Part 3, the Capital Adequacy (E) Task Force adopted proposal 2016-10-P at the 2017 Summer National Meeting. The original PR012 will be replaced by the PR012A. Also, the reinsurance credit risk component of R3 will no longer be needed to calculate in the new PR012 as these amounts will be directly linked to the Annual Statement blanks. The Blanks and Instructions were updated to reflect the change.

Catastrophe Risk

As a result of the adoption of proposal 2018-10-P by the Capital Adequacy (E) Task Force on its June 28 conference call, the "Yes" or "No" responses in PR027 were replaced by the checklist format. The purpose of this change is to make it clear that the PR027 interrogatory must be completed by the filers taking an catastrophe risk charge exemption on either earthquake, hurricane or both. The Blanks and Instructions were updated to reflect the change.

Stop Loss Interrogatories

As a result of the adoption of proposal 2018-01-CA by the Capital Adequacy (E) Task Force on its April 30 conference call, electronic only tables for stop loss interrogatories were added. Table 1 will be used to collect data to review and evaluate the stop loss factors. Table 2 will be used the capture the number of stop loss contracts by group size.

Medicaid Pass-Through Payments

As a result of the adoption of proposal 2017-08-CA, by the Capital Adequacy (E) Task Force at the 2018 Spring National Meeting, new lines (3.3) and (10.3) were added to page PR019 for Medicaid pass-through payments. The purpose of the change reflects that Medicaid Pass-Through Payments are more like uninsured business, such as ASC and ASOadministrative services contracts (ASC) and administrative services only (ASO), and should reflect a similar charge.

Federal ACA Changes

The Capital Adequacy (E) Task Force adopted proposal 2018-02-CA and proposal 2017-09-CA at the 2018 Spring National Meeting. proposal 2018-02-CA deleted the structure and instructions for the Underwriting Risk– Experience Fluctuation Risk—Informational Only page from the formula. proposal 2017-09-CA modifies the Risk Adjustment and Risk Corridor Sensitivity Test by removing the risk corridor portion. The purpose of these changes was due to discontinuation of the reinsurance and risk corridor programs, as well as the continued changes of the Federal Affordable Care Act (ACA).

Appendix 2 – Commonly Used Terms for Medicare Part D Coverage

As a result of the adoption of proposal 2018-03-CA by the Capital Adequacy (E) Task Force on its June 28 conference call, the individual definitions in Appendix 2—Commonly Used Terms for Medicare Part D Coverage were deleted, and a reference to Interpretation *(INT 05-05)*: Accounting for Revenue Under Medicare Part Coverage was added to reduce the misalignment of changes in the INT compared to the RBC instructions.

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New Industry Average Risk Factors – Annual Update

On its June 28 conference call, the Capital Adequacy (E) Task Force adopted the annual update of industry average development factors:

PR017 Underwriting Risk – Reserves

Line (1), Industry Average Development Factors

Col.	Line of Business	2017 Factor	2018 Factor
(1)	H/F	0.984	**0.989**
(2)	PPA	1.012	**1.022**
(3)	CA	1.034	**1.060**
(4)	WC	0.971	**0.952**
(5)	CMP	0.956	**0.967**
(6)	MPL Occurrence	0.868	**0.871**
(7)	MPL Clms Made	0.854	**0.886**
(8)	SL	0.926	**0.933**
(9)	OL	0.952	**0.966**
(10)	Fidelity/Surety	1.016	**0.996**
(11)	Special Property	0.982	**0.971**
(12)	Auto Physical Damage	1.001	**1.000**
(13)	Other (credit A&H)	0.981	**[illegible].976**
(14)	Financial/Mortgage Guaranty	0.820	**0.8[illegible]**
(15)	INTL	0.855	**0.851**
(16)	REIN. P&F Lines	0.814	**0.834**
(17)	REIN. Liability	0.9[illegible]4	**0.945**
(18)	PL	[illegible]93[illegible]	**0.921**
(19)	Warranty	0.98[illegible]	**1.015**

PR018 Underwriting Risk – Net Written Premiums

Line (1), Industry Average Loss and Expense Ratios

Col.	Line of Business	20[illegible] Factor	2018 Factor
(1) *	H/F	[illegible].68[illegible]	**0.687**
(2)	PPA	0.8[illegible]0	**0.806**
(3)	CA	0.706	**0.724**
(4)	WC	0.751	**0.744**
(5) *	CMP	0.647	**0.664**
(6)	MPL Occu[illegible]e	0.777	**0.780**
(7)	[illegible]L Clm[illegible] Made	0.722	**0.747**
(8) *	[illegible]L	0.567	**0.569**
(9)	OL	0.629	**0.633**
(10)	Fidelity/Surety	0.430	**0.417**
(11)	Special Property	0.555	**0.563**
(12)	Auto Physical Damage	0.727	**0.732**
(13)	Other (credit A&H)	0.712	**0.709**
(14)	Financial/Mortgage Guaranty	1.175	**1.099**
(15) *	INTL	0.565	**0.584**
(16) *	REIN. P&F Lines	0.459	**0.486**
(17) *	REIN. Liability	0.609	**0.666**
(18)	PL	0.670	**0.671**
(19)	Warranty	0.645	**0.732**

* Cat Lines

RBC Forecasting and Instructions

The NAIC 2*018 Property and Casualty Risk-Based Capital Forecasting & Instructions* is available for purchase through the NAIC Publications Department. Customers who purchase this publication can download the forecasting spreadsheet from the NAIC Account Manager. This publication is available for purchase on or about November 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

WARNING: The RBC Forecasting Spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.

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2018 NAIC Property and Casualty

Risk-Based Capital Report

Including

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as of December 31, 2018

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Table of Contents

INTRODUCTION i
PURPOSE OF THIS REPORT i
WHAT'S IN THE REPORT i
MANAGEMENT DISCUSSION AND ANALYSIS ii
APPLICABILITY OF NAIC PROPERTY/CASUALTY RBC REPORT ii
CHANGES TO THE FORMULA ii
HOW TO SUBMIT DATA iii
WORKPAPERS iii
QUESTIONS iii
AFFILIATED STOCKS AND BONDS, PR003 – PR005 1
- Insurance Affiliates that are Subject to RBC 1
  - Directly Owned U.S. Property & Casualty Insurance Affiliates 3
  - Directly Owned U.S. Life Insurance Affiliates 3
  - Directly Owned Health Insurance Affiliates 3
  - Indirectly Owned U.S. P&C Insurance Affiliates 4
  - Indirectly Owned U.S. Life Insurance Affiliates 5
  - Indirectly Owned Managed Care Organizations 5
  - Investment Affiliates 5
- Affiliates that are Not Subject to RBC 5
  - Directly Owned Alien Insurance Affiliates 6
  - Indirectly Owned Alien Insurance Affiliates 6
  - Holding Company Value in Excess of Indirectly Owned Insurance Affiliates 6
  - Investment in Upstream Affiliate (Parent) 6
  - Property & Casualty Insurance Affiliates Not Subject to RBC 6
  - Life Insurance Affiliates Not Subject to RBC 6
  - Health Insurance Affiliates Not Subject to RBC 7
  - Other Affiliates 7

UNAFFILIATED ASSETS, PR006 – PR014 8
- PR006 - Unaffiliated Bonds and Bond Size Factor Adjustment 8
  - Basis of General Bond Factors 8
  - Bond Size Factor 8
- PR007 - Unaffiliated Preferred, Common Stock and Hybrid Securities 9
  - Unaffiliated Preferred Stock 9
  - Unaffiliated Common Stock 9
- PR008 - Other Long–Term Assets 9
  - Real Estate 9
  - Mortgage Loans on Real Estate 9
  - Schedule BA Assets (Other Invested Assets – excluding collateral loans, low income housing tax credits and WCFI) 9
  - Low Income Housing Tax Credits 10
  - Working Capital Finance Investments 10

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PR009 - Miscellaneous Assets 10
PR010 - Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities 11
Basis of Factors 11
Specific Instructions for Application of Formula 11
PR011 - Asset Concentration 12
PR012 - Credit Risk for Receivables 13
Reinsurance Recoverables 13
Miscellaneous Recoverables 13
PR012A - Credit Risk for Receivables For Informational Purposes Only 14
Reinsurance Recoverables 14
Miscellaneous Recoverables 15
PR013 - Health Credit Risk 15
Basis of Factors 16
Specific Instructions for Application of the Formula 16
PR014 - Off-Balance Sheet and Other Items 18
Specific Instructions for Application of the Formula 18
OFF-BALANCE SHEET COLLATERAL AND SCHEDULE DL, PART 1 ASSETS, PR015 20
Specific Instructions for Application of the Formula 20
EXCESSIVE PREMIUM GROWTH, PR016 21
UNDERWRITING RISK, PR017 – PR018 22
PR017 - Underwriting Risk – Reserves 22
PR018 - Underwriting Risk – Net Written Premiums 24
LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS, PR019 – PR026 26
PR019 - Health Premiums 26
Basis of Factors 26
Specific Instructions for Application of the Formula 26
PR020 - Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental and Vision 31
Claims Experience Fluctuation 31
PR020A - Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental and Vision (For Informational Purposes Only) 36
PR021 - Underwriting Risk – Managed Care Credit 42
PR022 - Underwriting Risk – Other and Total Net Health Premium RBC 46
Administrative Expenses for Certain A&H Coverage and for Health ASO/ASC 46
Specific Instructions for Application of the Formula 46
PR023 - Long-Term Care 47
PR024 - Health Claim Reserves 47
PR025 - Premium Stabilization Reserves 47
Basis of Factors 47
Specific Instructions for Application of the Formula 47
PR026 – Federal ACA Risk Adjustment and Risk Corridor Sensitivity Test 48
CALCULATION OF CATASTROPHE RISK CHARGE R6 AND R7 AND OPERATIONAL RISK, PR027 – PR028 50
PR027 – Calculation of Catastrophe Risk Charge R6 and R7 (For Informational Purposes Only) 50
PR028 – Operational Risk (For Informational Purposes Only) 52

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TOTAL ADJUSTED CAPITAL AND COMPARISON TO RISK–BASED CAPITAL, PR029 – PR035 53
PR029 - Capital Notes Before Limitation 53
PR030 - Calculation of Total Adjusted Capital 53
PR031 – PR033 - Computation of Total Risk-Based Capital After Covariance 54
PR035 - Comparison of Total Adjusted Capital and Authorized Control Level Risk-Based Capital 56
APPENDIX 1 - COMMONLY USED HEALTH INSURANCE TERMS 57
APPENDIX 2 – COMMONLY USED TERMS FOR MEDICARE PART D COVERAGE 59
COMPANY INFORMATION PAGE (JURAT) PR001
ATTESTATION RE: CATASTROPHE MODELING USED IN RBC CATASTROPHE RISK CHARGES PR002
DETAILS FOR AFFILIATED BONDS AND STOCKS PR003
SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS PR004
SUMMARY FOR SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS FOR CROSS-CHECKING STATEMENT VALUES PR005
UNAFFILIATED BONDS PR006
UNAFFILIATED PREFERRED, COMMON STOCK AND HYBRID SECURITIES PR007
OTHER LONG-TERM ASSETS PR008
MISCELLANEOUS ASSETS PR009
REPLICATION (SYNTHETIC ASSET) TRANSACTIONS AND MANDATORY CONVERTIBLE SECURITIES PR010
ASSET CONCENTRATION PR011
CREDIT RISK FOR RECEIVABLES PR012
HEALTH CREDIT RISK PR013
OFF-BALANCE SHEET ITEMS AND OTHER ITEMS PR014
OFF-BALANCE SHEET COLLATERAL AND SCHEDULE DL, PART 1 ASSETS PR015
EXCESSIVE PREMIUM GROWTH PR016
UNDERWRITING RISK – RESERVES PR017
UNDERWRITING RISK – NET WRITTEN PREMIUMS PR018
HEALTH PREMIUMS PR019
UNDERWRITING RISK – PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION PR020
UNDERWRITING RISK – MANAGED CARE CREDIT PR021
UNDERWRITING RISK – OTHER AND TOTAL NET HEALTH PREMIUM RBC PR022
LONG-TERM CARE PR023
HEALTH CLAIM RESERVES PR024
PREMIUM STABILIZATION RESERVES PR025
FEDERAL ACA RISK ADJUSTMENT AND RISK CORRIDOR SENSITIVITY TEST PR026
CALCULATION OF CATASTROPHE RISK CHARGE R6 AND R7 (FOR INFORMATIONAL PURPOSES ONLY) PR027
CAPITAL NOTES BEFORE LIMITATION PR028
CALCULATION OF TOTAL ADJUSTED CAPITAL PR029
CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PR030
TREND TEST PR033
COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL PR034
UNDERWRITING AND INVESTMENT EXHIBIT – PREMIUMS WRITTEN PR035
SCH F PT 3 REINSURANCE CREDIT AND MED TABULAR RESERVE PR038
GROSS WRITTEN PREMIUMS PR039

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NAIC Property/Casualty Risk-Based Capital Report

INTRODUCTION

Risk-based capital is a method of establishing the minimum amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size and risk profile. It provides an elastic means of setting the minimum capital requirement in which the degree of risk taken by the insurer is the primary determinant.

A company's risk-based capital is calculated by applying factors to various asset, premium and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of a company's actual capital may then be measured by a comparison to its risk-based capital as determined by the formula.

Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to insurers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in conservatorship.

PURPOSE OF THIS REPORT

This report presents the **2018** NAIC Property/Casualty Risk-Based Capital formula in an instructional format that should be helpful to anyone: (a) responsible for submitting data to the NAIC and/or the states or (b) responsible for computing the RBC for an individual company.

This formula is an important tool for regulators. Determining accurate and timely data is an extremely important part of this process. This is most likely to occur when everyone, from the company CEO to the individual preparing the data, has a basic understanding of the formula. *While this report provides this understanding in a concise package, it is strongly recommended that the person or persons preparing and entering the information be senior company officials with a good understanding of the financial aspects of property/casualty insurance. It is also recommended that companies seek the assistance of their independent accountants and/or actuaries when preparing the risk-based capital report. Please complete the Jurat Signature requirements in accordance with the requirements of the domiciliary state. Direct any questions concerning signature requirements to that state.*

WHAT'S IN THE REPORT

Certain terms relating to risk-based capital, used in this report, are defined in the Risk-Based Capital (RBC) for Insurers Model Act.

Generally, each narrative section discusses a different segment of the formula (e.g., there is a narrative on Bonds and a narrative on Underwriting Risk). The formula itself is presented in worksheet form in a separate section of this booklet immediately following this narrative. The formula pages are broken down into sections as follows:

1) Company Information (Jurat Page)
2) Affiliated Stocks and Bonds
3) Unaffiliated Assets
4) Credit Risk and Health Credit Risk
5) Underwriting Risk
6) Life RBC Formula Application for P&C Company's A&H Business
7) Total Adjusted Capital

Most narrative pages have a brief summary of the background of the development of the factors, called the "Basis of the Factors." Development of certain factors required sophisticated modeling techniques but the basic concepts are not complicated. Many sections of this report include a section on "Specific Instructions for Application of the Formula"

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which serves as a guide for those who assemble the data or analyze the results of the formula. It includes definitions and explanations for specific items that should be calculated, clarifications on the intent of the structure of certain sections of the formula, and instructions on reconciliation of certain totals.

Annual statement sources referred to in this report do not use parentheses; i.e., a reference to Page 2, Line 19, Column 1 in the annual statement will read P2 L19 C1. Annual statement references will begin with a page number only for pages 2 and 3. Otherwise the reference will be an Exhibit number or description (e.g., Exhibit 1), a schedule letter (e.g., Schedule D) or a name of an Exhibit or Schedule (e.g., U&I Exhibit–Part 1B). This is to avoid the necessity of changing page numbers for references in the future. References to sources in this report will use parentheses around the line and column number. A reference to Miscellaneous Assets, Line 9, Column 2 in this report will read Miscellaneous Assets L(9) C(2).

MANAGEMENT DISCUSSION AND ANALYSIS

Each company has the opportunity to prepare a written analysis of its risk-based capital results. A company may explain special situations as it deems necessary. Companies should also give explanations where totals of line items do not reconcile with totals that are referenced to annual statement sources. However, modification of the risk-based capital formula is not acceptable. Factors, RBC amounts that go to the Calculation of Total Risk-Based capital After Covariance page (R0, R1, R2, R3, R4, R5 and Rcat), and the Total Adjusted Capital amount should not be overwritten. This written analysis should not be construed as the "RBC Plan" required in the Risk-Based Capital (RBC) for Insurers Model Act.

APPLICABILITY OF NAIC PROPERTY/CASUALTY RBC REPORT

The NAIC Property/Casualty RBC Report has been developed for U.S. property/casualty and accident and health insurers who file the NAIC property/casualty annual statement blank (yellow blank), including captive risk retention groups (RRGs). Monoline financial guaranty insurers, monoline mortgage guaranty insurers and title insurers are not subject to risk-based capital. In some states, U.S. companies that write only alien business may be excluded from risk-based capital requirements. In addition, states in which Blue Cross/Blue Shield and similar organizations file the yellow blank may decide to exempt these companies from filing an RBC report based on the extent to which the operations of these entities are different from conventional insurers' individual and group health insurance operations. Other single state specialty insurers not subject to rules applicable to property/casualty insurers may also be exempt. If there are any questions related to this issue, contact the domiciliary state of the insurer.

Captive RRGs generally maintain their books and prepare their financial statements on the basis of GAAP whereas this formula was developed for use with insurers that utilize statutory accounting principles (SAP). Therefore, certain manual modifications should be made for purposes of applying this RBC formula. In particular, undiscounted reserves must be used in this RBC formula. Further, if an RRG is discounting its loss reserves carried on its balance sheet under an approved plan of operations, the amount of the discount shall be deducted from its total adjusted capital in this RBC formula. This is the same treatment required of traditional companies as failure to use undiscounted reserves in the RBC formula and to deduct the amount of the discount from total adjusted capital results in a double-counting of the discount.

Captive RRGs may make additional modifications, eliminations and/or reclassifications of GAAP assets or liabilities only with the express approval of the domestic regulator when completing this RBC formula. Further, RRG domiciles may issue instructions to domestic RRGs regarding accounting for and classification or reclassification of GAAP assets and liabilities, and LOCs, within this RBC formula.

In addition, some RRGs are allowed under the laws of the domestic state to use Letters of Credit (LOCs) for capital purposes. Such LOCs shall be included in surplus and total adjusted capital in this RBC formula.

CHANGES TO THE FORMULA

Changes to the formula may be made necessary by annual statement presentation, accounting procedures and refinement of the formula. All such changes will be determined by the NAIC Capital Adequacy (E) Task Force.

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HOW TO SUBMIT DATA

Printed RBC reports and electronic submissions should be submitted as specified in the individual state filing checklists. There may be places where the screen display of the RBC program and the printout format vary slightly from the booklet. In those instances, the booklet should explain the differences; however, the overall calculation will be the same.

WORKPAPERS

Workpapers needed to prepare this report should be retained and available for examination in accordance with record retention requirements of the domestic state laws or regulations.

QUESTIONS

Contact Eva Yeung by phone at 816-783-8407 or by e-mail at eyeung@naic.org for RBC formula questions.

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AFFILIATED STOCKS
PR003 – PR005

There are fifteen categories of subsidiary and affiliated investments that are subject to RBC requirement for common stock **and** preferred stock holdings. Those fifteen categories are:

1. Directly Owned P&C Insurance Affiliates Subject to RBC
2. Directly Owned Life Insurance Affiliates Subject to RBC
3. Directly Owned Health Insurance Affiliates Subject to RBC
4. Indirectly Owned P&C Insurance Affiliates Subject to RBC
5. Indirectly Owned Life Insurance Affiliates Subject to RBC
6. Indirectly Owned Health Insurance Affiliates Subject to RBC
7. Investment Affiliates
8. Directly Owned Alien Insurance Affiliates
9. Indirectly Owned Alien Insurance Affiliates
10. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates
11. Investments in Upstream Affiliate (Parent)
12. P&C Insurance Affiliates Not Subject to RBC
13. Life Insurance Affiliates Not Subject to RBC
14. Health Insurance Affiliates Not Subject to RBC
15. Other Affiliates

Enter applicable items for each affiliate in the Details for Affiliated Stocks worksheet. The program will automatically calculate the RBC charge for each affiliate. When the data is uploaded to the NAIC database, it will be cross-checked and the company will be required to correct any discrepancies and refile a corrected version with the NAIC and/or any state that requires the company to file RBC with its department. The diskette will display the number of subsidiaries and affiliates. These numbers should be reviewed to ensure that all subsidiaries and affiliates are appropriately reported.

Affiliated investments fall into two broad categories: (a) Insurance Affiliates that are Subject to RBC; and (b) Affiliates that are Not Subject to RBC. The RBC for these two broad groups differs, therefore, the general treatment is explained below.

<u>Insurance Affiliates that are Subject to RBC</u>
For purposes of Affiliate Risk all references to Total Risk-Based Capital After Covariance of the subsidiary or affiliate means:
• For a Health subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (XR025, Line (37));
• For a P/C subsidiary RBC filing, Total Risk-Based Capital After Covariance before Basic Operational Risk (PR032, Line (**68**)); and
• For a Life subsidiary RBC filing, the sum of
(a) Total Risk-Based Capital After Covariance before Basic Operational Risk (LR031, Line (67); and
(b) Primary Security shortfalls for all cessions covered by Actuarial Guideline XLVIII (AG 48) **multiplied by two** (LR031, Line (**71**)).

For those insurance affiliates of the reporting company that are reported under the equity method, and for which unamortized admitted goodwill is zero or non-existent for the reported book/adjusted carrying value, the RBC charge of the ownership of common stock in these affiliates is limited to the lesser of (a) the Total RBC After Covariance of the affiliate times the percentage of ownership of total common stock; or (b) the common stock book/adjusted carrying value greater than zero at which the affiliate is carried. To establish the percentage of ownership of common stock, the book/adjusted carrying value of the insurance affiliate must be entered in Column (5) of the appropriate worksheet and the total outstanding common stock of that affiliate must be entered in Column (7).

Not for Distribution

For all other insurance affiliates of the reporting company, the RBC charge of the ownership of common stock in these affiliates consists of two components:

(1) The R_0 component, which is limited to the lesser of (a) the Total RBC After Covariance of the affiliate times the percentage of ownership of total common stock; or (b) the statutory surplus of the affiliate times the percentage of ownership of total common stock.

(2) The R_2 component, which is computed in the following manner:
If the Total RBC After Covariance of the affiliate times the percentage of ownership of total common stock is greater than the book / adjusted carrying value, the R_2 component is set equal to the amount of the book / adjusted carrying value of the common stock that exceeds the value obtained from the R_0 component (step (1)(b) above).

Otherwise, the R_2 component is set equal to the larger of (a) 22.5 percent times the excess of book / adjusted carrying value over the pro rata statutory surplus value for the affiliate; and (b) the amount that Total RBC After Covariance of the affiliate times the percentage of ownership of total common stock exceeds the value obtained from the R_0 component.
In any case, the R_2 component is limited to a floor of zero.

The RBC charge for ownership of preferred stock on these affiliates is somewhat more complex and depends on whether there is *excess RBC* over and above the total value of the outstanding common stock. Excess RBC is defined as the amount that the Total RBC After Covariance of the affiliate exceeds the common stock book/adjusted carrying value for the investment in that affiliate. If the Total RBC After Covariance of the affiliate is less than the common stock book/adjusted carrying value for the investment in that affiliate, then there is no excess RBC and there is no RBC charge for the ownership of the preferred stock. If there is excess RBC, then the charge for ownership of the preferred stock is the lesser of (a) the pro rata share of the excess RBC; or (b) the reporting company's book/adjusted carrying value of the preferred stock greater than zero. The pro rata ownership of preferred stock is the ratio of the affiliate's preferred stock in Column (10) of the affiliated worksheet to the value of all outstanding preferred stock in Column (11). The pro rata share is multiplied by the excess RBC and compared to the carrying value of preferred stock in Column (10).

To determine the value of total outstanding common stock or total outstanding preferred stock, divide the book/adjusted carrying value of the investment (found in Schedule D - Part 6 Section 1, Column 7) by the percentage of ownership (found in Schedule D – Part 6 Section 1, Column 9). For example:

Affiliated Insurance Company	Owner's Book / Adjusted Carrying Value	Percentage Ownership	Total Common Stock Outstanding
Affiliate #1	$1,000,000	100%	$1,000,000
Affiliate #2	$1,000,000	75%	$1,333,333
Affiliate #3	$1,000,000	50%	$2,000,000
Affiliate #4	$1,000,000	25%	$4,000,000
Affiliate #5	$1,000,000	10%	$10,000,000

In some instances, a company may own preferred stock in an affiliate subject to RBC yet hold no common stock. In **this** instance, the company must compute the notional value of the outstanding value of the affiliate's common and/or preferred stock to determine if there is any excess. Valuation of the total outstanding common and preferred stock must be based on one of the accepted methods outlined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office.*

*In the rare case where Total RBC After Covariance exceeds the carrying value (market), which in turn exceeds statutory surplus, the formula will apply 100 percent of the difference between the market and surplus values as an additional RBC charge to the R_2 component. The amount of statutory surplus (adjusted for percentage ownership) continues to be added to the formula's R_0 component.

Also, note that the formula compares the amount generated by 22.5 percent of market carrying value less statutory surplus to the amount of RBC After Covariance less statutory surplus and increases the R_2 component by the larger amount. This is done in order to satisfy the initial requirement that the RBC charge for ownership of such common stock is

Not for Distribution

limited to the lesser of RBC After Covariance or the financial statement carrying value of the insurer (both adjusted for percentage ownership). The situation can occur where the market carrying value is greater than RBC After Covariance, which in turn is greater than statutory surplus, which leads to the need to make this comparison.

Directly Owned U.S. Property & Casualty Insurance Affiliates

Enter information regarding any top-layer directly owned U.S. property & casualty insurance affiliates in the Directly Owned U.S. Property & Casualty Insurance Affiliates worksheet. For each affiliate enter its name, affiliate code, NAIC company code, affiliate's Total RBC After Covariance, book/adjusted carrying value of the common stock from Schedule D Part 6 Section 1, and total outstanding common stock of that affiliate in Columns (1) through (8). The required RBC will be automatically calculated by the program. If no value is entered in the Total Value of Affiliate's Common Stock column, Column (7), then the program will assume 100 percent ownership. If the reporting company does not own any of the affiliate's common stock but does own either preferred stock or bonds, the Total Value of Affiliate's Common Stock must be entered in Column (7) so that the program can calculate whether any excess RBC exists. The RBC charge for the ownership of the affiliate's common stock will be automatically calculated; however, the required RBC cannot exceed the book/adjusted carrying value of the common stock in Column (5).

The book / adjusted carrying value of any preferred stock must be entered in Column (10) and the total outstanding value of the affiliate's preferred stock must be entered in Column (11). Again, the percentage of ownership and the RBC required for the ownership of preferred stock will be automatically calculated. Even if the reporting company does not own any of the affiliate's preferred stock, the total outstanding value of that affiliate's preferred stock must be entered so that the program will correctly calculate any excess RBC.

The risk-based capital to be entered for each affiliate property and casualty insurer should be obtained by using a separate copy of the RBC program for each affiliate. Monoline financial guaranty insurers, monoline mortgage guaranty insurers and title insurers are not subject to risk-based capital. These affiliates and other similar affiliates should be reported as P&C Insurance Affiliates Not Subject to RBC.

Directly Owned U.S. Life Insurance Affiliates

Enter information regarding any top-layer directly owned U.S. life insurance affiliates in the schedule for directly owned companies in the Affiliated Bonds and Stock worksheet. For each affiliate enter the same information as that required for directly owned P&C insurance affiliates that are subject to RBC. If a U.S. life insurance affiliate is not subject to RBC, then it should be treated as Life Insurance Affiliates Not Subject to RBC.

The risk-based capital of each Life affiliate should be obtained by using a separate copy of the Life RBC program for each affiliate.

Directly Owned Health Insurance Affiliates

Enter information regarding any top-layer directly owned Health Insurance affiliates in the schedule for directly owned companies in the Affiliated Bonds and Stock worksheet. For each affiliate enter the same information as that required for directly owned P&C insurance affiliates that are subject to RBC. If a HEALTH INSURANCE affiliate is not subject to RBC, then it should be treated as Health Insurance Affiliates Not Subject to RBC.

The risk-based capital of each Health Insurance affiliate should be obtained by using a separate copy of the Health RBC program for each affiliate.

Indirectly Owned U.S. P&C Insurance Affiliates

The first step in entering information on indirectly owned U.S. insurance affiliates that are subject to RBC is to allocate the reporting entity's book/adjusted carrying value of the holding company between any top-layer, indirectly owned insurance affiliates and the Holding Company Value in Excess of Indirectly Owned Insurance Affiliates. To do that, the

Not for Distribution

carrying value of the holding company is first allocated based on the values shown on the holding company's balance sheet. The following example shows a hypothetical holding company, Holder Inc., that is 100 percent owned by Bigun Insurance Company and shows the allocation of Holder's carrying value among these categories:

Balance Sheet
Holder, Inc.
12/31/XXXX

ABC Life	$4,000,000	Long-Term Debt	$14,000,000
XYZ Casualty	$2,000,000	Other Liabilities	$5,000,000
Non-U.S. Casualty	$6,000,000		
GX Todd Real Estate	$4,000,000		
Cash	$5,000,000	Equity	$5,000,000
Other Assets	$3,000,000		
Total Assets	$24,000,000	Total Liab & Equity	$24,000,000

Since ABC Life Insurance Company makes up 1/6 ($4,000,000/$24,000,000) of the total assets for Holder, Inc., then this indirectly owned U.S. affiliate represents 1/6 of the carrying value of Holder, Inc. on the statement of Bigun Insurance Company. Similarly, the indirectly owned U.S. affiliate XYZ Casualty represents 1/12 of the carrying value ($2,000,000/$24,000,000) of Holder on Bigun's annual statement. Non-U.S. Casualty, which is an alien insurance affiliate, represents 1/4 of the carrying value ($6,000,000/$24,000,000) of Holder on Bigun's annual statement. One-half of the carrying value of Holder, Inc. ($12,000,000/$24,000,000) represents the Holding Company Value in Excess of Indirectly Owned Insurance Affiliates. If Bigun Insurance Company carries Holder, Inc. on its annual statement at $30,000,000 (assume that this is the current fair value of shares in Holder, which was a publicly traded corporation of which Bigun has just acquired 100 percent ownership), then Bigun will allocate 1/6 of that $30,000,000 to ABC Life, 1/12 of that $30,000,000 to XYZ Casualty, 1/4 of that $30,000,000 to Non-U.S. Casualty, and 1/2 to Holder under the category Holding Company Value in Excess of Indirectly Owned Insurance Affiliates. The RBC charge for the indirect ownership of common stock in ABC Life will be computed as the lesser of ABC Life's Total RBC After Covariance or $5,000,000 (1/6 of $30,000,000). The RBC charge for the indirect ownership of XYZ Casualty will be the lesser of XYZ's Total RBC After Covariance or $2,500,000 (1/12 of $30,000,000).

If Bigun only acquired 50 percent of the shares of Holder, then these values must be adjusted to reflect Bigun's partial ownership and a determination made as to the nature of the carrying value of Holder. If Holder's carrying value is based on other than fair value, then the allocations follow as described in (a). If the carrying value of Holder is based on its fair value, then the allocations and any additional RBC due to the use of fair value are described in (b).

(a) Now the carrying value (not based on fair value) on Bigun's annual statement is $15,000,000 which is allocated as $2,500,000 to ABC Life (1/6 of $15,000,000), $1,250,000 to XYZ Casualty (1/12 of $15,000,000) as Indirectly Owned U.S. Insurance Affiliates, $3,750,000 to Non-U.S. Casualty (1/4 of $15,000,000) as Indirectly Owned Alien Insurance Affiliate, and $7,500,000 to Holder as the Holding Company Value in Excess of Indirectly Owned Insurance Affiliates. The RBC After Covariance for the indirectly owned U.S. insurance affiliates is also adjusted by 50% to reflect Bigun's percentage of ownership. Therefore, Bigun will enter $2,500,000 as the carrying value for ABC Life in Column (5) and $5,000,000 ($2,500,000 / 0.50) as the total outstanding common stock in Column (7).

(b) In this example, the carrying value (based on fair value) on Bigun's annual statement is $18,000,000, which will be allocated in the same manner described in (a) above. However, one additional step is added regarding the indirectly* owned U.S. Insurance Affiliates that are subject to RBC. For example, assume that the carrying value (based on fair value) of ABC on Bigun's annual statement is larger than ABC's RBC After Covariance (prorated 50 percent for its partial ownership), the amount of Holder applicable to ABC Life ($3,000,000: 1/6 of $18,000,000) will be reduced by its statutory surplus** (prorated 50 percent for its partial ownership), and if a positive amount results, then the larger of that amount times 22.5 percent or the excess of ABC's RBC After Covariance (prorated 50 percent for its ownership) over the value obtained from step (a) will be reported as a R2 component of such stock in the formula. The same will apply to XYZ Casualty.

Not for Distribution

The information for all top-layer, indirectly owned U.S. property and casualty insurance affiliates and indirectly owned U.S. life insurance affiliates is entered in the appropriate columns in the Affiliated Stocks worksheet. For each affiliate enter its name, affiliate code, NAIC company code and the pro-rata share of risk-based capital along with all other information required in Columns (1) through (**11**). If the amount in Column (5) is based on fair value, then place an "F" in Column (6) and the affiliate's statutory capital and surplus (adjusted for ownership) in Column (8). The RBC charge (if any) will be calculated by the formula with the result appearing in Columns (**13**) and (**14**).

Indirectly Owned U.S. Life Insurance Affiliates

Indirectly owned U.S. life insurance affiliates are treated in a manner similar to indirectly owned P&C insurance affiliates. Note that the insurance affiliate must be subject to RBC and file an RBC report to be included in this section. Otherwise, the affiliate's value will be included in the Holding Company Value in Excess of Insurance Affiliates section.

Indirectly Owned Managed Care Organizations

Indirectly owned Managed Care affiliates are treated in a manner similar to indirectly owned P&C insurance affiliates. Note that the insurance affiliate must be subject to RBC and file an RBC report to be included in this section. Otherwise, the affiliate's value will be included in the Holding Company Value in Excess of Insurance Affiliates section.

Affiliates that are Not Subject to RBC

This category includes these categories of affiliated investments:

7. Investment Affiliates
8. Directly Owned Alien Insurance Affiliates
9. Indirectly Owned Alien Insurance Affiliates
10. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates
11. Investment in Upstream Affiliate (Parent)
12. P&C Insurance Affiliates Not Subject to RBC
13. Life Insurance Affiliates Not Subject to RBC
14. Health Insurance Affiliates Not Subject to RBC
15. Other Affiliates

The RBC charge for these investments is calculated by multiplying a factor times the book/adjusted carrying value of the common stock, preferred stock and bonds of those affiliates.

Investment Affiliates

An investment affiliate is an affiliate that exists only to invest the funds of the parent company. The term investment affiliate is strictly defined in the annual statement instructions as any affiliate, other than a holding company, engaged or organized primarily to engage in the ownership and management of investments for the insurer. An investment affiliate shall not include any broker-dealer or a money management fund managing funds other than those of the parent company. The risk-based capital for an investment in an Investment Affiliate is 0.225 times the carrying value of the common and preferred stock.

Directly Owned Alien Insurance Affiliates

For purposes of this formula, the risk-based capital of each directly owned alien insurance affiliate is the annual statement carrying value of the reporting company's interest in the affiliate multiplied by 0.500. Enter information for any non-U.S. insurance affiliates; life, property and casualty and health insurers. For each affiliate, enter the name of the affiliate, Alien Insurer Identification Number, the book/adjusted carrying value of common stock **and** preferred stock.

Not for Distribution

Indirectly Owned Alien Insurance Affiliates

The risk-based capital of each indirectly owned alien insurance affiliate is the carrying value of the holding company's interest in the affiliate multiplied by 0.500, and adjusted to reflect the reporting company's ownership on the holding company. In the prior example, in the case that Bigun acquired 100 percent of the shares of Holder, Bigun will enter $7,500,000 (1/4 of $30,000,000) as the carrying value for Non-U.S. Casualty and the RBC charge for the indirect ownership of this alien insurance affiliate will be $3,750,000 (0.500 times $7,500,000). In the case that Bigun only acquired 50 percent of Holder, Bigun will enter $3,750,000 (50 percent of 1/4 of $30,000,000) for Non-U.S. Casualty and the RBC charge for this indirectly owned alien insurance affiliate will be $1,875,000 (0.500 times $3,750,000).

Holding Company Value in Excess of Indirectly Owned Insurance Affiliates

The risk-based capital charge for the parent insurer preparing the calculation is a 22.5 percent charge against the holding company value in excess of the indirectly owned insurance affiliates as calculated in the prior example. Enter information in the appropriate columns of the worksheet, omitting those columns that do not apply (Column (3) – NAIC Company Code or Alien ID Number and Column (4) Affiliate's RBC After Covariance).

Investment in Upstream Affiliate (Parent)

The risk-based capital for an investment in an upstream parent is 0.225 times the carrying value of the common and preferred stock, regardless of whether that upstream parent is subject to RBC. Enter the appropriate information in Columns (1) through (**11**).

Property & Casualty Insurance Affiliates Not Subject to RBC

Insurance affiliates that are not subject to RBC, such as title insurers, monoline financial guaranty insurers, and monoline mortgage guaranty insurers are classified as P&C Insurance Affiliates Not Subject to RBC. The risk-based capital for P&C Insurance Affiliates Not Subject to RBC is 0.225 times the book/adjusted carrying value of the common stock **and** preferred stock of those affiliates.

Life Insurance Affiliates Not Subject to RBC

The risk-based capital for Life Insurance Affiliates Not Subject to RBC is 0.225 times the book/adjusted carrying value of the common stock **and** preferred stock of those affiliates.

Health Insurance Affiliates Not Subject to RBC

The risk-based capital for Health Insurance Affiliates Not Subject to RBC is 0.225 times the book/adjusted carrying value of the common stock **and** preferred stock of those affiliates.

Other Affiliates

Non-insurance affiliates and insurance affiliates that are not included elsewhere, are classified as Other Affiliates. The risk-based capital for an investment in an Other Affiliate is 0.225 times the carrying value of the common and preferred stock.

Not for Distribution

ASSETS
PR006 – PR014

PR006 - Bonds and Bond Size Factor Adjustment

Basis of General Bond Factors

These bond factors are based on cash flow modeling using historically adjusted default rates for each bond category. For each of 2,000 trials, annual economic conditions were generated for the 10-year modeling period. Each bond of a 400-bond portfolio was annually tested for default (based on a "roll of the dice") where the default probability varies by NAIC Designation category and that year's economic environment.

The factors for NAIC 03 through 06 recognize that these bonds are marked to market.

Bond Size Factor

The size factor reflects additional modeling for different size portfolios that shows the risk increases as the number of bond issuers decreases. Because most insurers' bond portfolios are considerably smaller than the portfolio used to develop the model bond risk, the basic bond factors understate the true default risk of these assets. The bond size factor adjusts the computed RBC for those bonds that are subject to the size factor to more accurately reflect the risk.

The bond size factor is to be multiplied by the risk-based capital of the bonds subject to the size factor. This calculation produces the *additional* RBC required for a portfolio that has less than 1,300 bonds in it. Portfolios with more than 1,300 issuers will receive a discount. The bond size factor was developed as a step factor (as in a tax table) so that the overall factor decreases as the portfolio size increases. Bonds should be aggregated by issuer (the first six digits of the CUSIP number should be used for aggregation). In determining the total number of issuers, do not count:

- U.S. government bonds that are direct and guaranteed and backed by the full faith and credit of the U.S. government which receive a zero factor (see Annual Statement Instructions).
- Bonds in NAIC 01 (highest quality) which are issued by a U.S. government agency but that are not backed by the full faith and credit of the U.S. government. Examples of these bonds are: FNMA and FHLMC collateralized mortgage obligations.

The calculation shown below will not appear in the software but will be calculated automatically. However, you must enter the total number of issuers in the appropriate field on the RBC filing software. If you leave this field blank, the program will assume that there are less than 50 issuers and will default to the maximum bond size factor adjustment. The calculation to derive the bond size factor is:

	Source	(a) No of Issuers				(b) Wgtd Issuers
First 50	Co Records	______	X	2.5	=	______
Next 50	Co Records	______	X	1.3	=	______
Next 300	Co Records	______	X	1.0	=	______
Over 400	Co Records	______	X	0.9	=	______
Total	Co Records	______				______

Size Factor = Total Weighted Issuers/Total No of Issuers less 1

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PR007 - Unaffiliated Preferred, Common Stock and Hybrid Securities

Unaffiliated Preferred Stock

Detailed information on unaffiliated preferred stocks and Hybrid Securities are found in Schedule D Part 2 Section 1 and Schedule D Part 1A Section 1 of the annual statement respectively. The preferred stocks and hybrid securities must be broken out by NAIC Designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines of the RBC software. The total amount of unaffiliated preferred stock reported should equal annual statement P2 L2.1 C3 less any affiliated preferred stock in Schedule D-Summary by Country C1 L18. The total amount of hybrid securities reported should equal annual statement Schedule D Part 1A Section 1 **C7** L7.7.

Unaffiliated Common Stock

Unaffiliated common stocks are subdivided into non-government money market funds and all other unaffiliated common stocks. Non-government money market mutual funds are now reported as cash equivalents and will receive the same charge as cash equivalents. Amounts reported as non-government money market funds should reflect only those money market funds not qualifying for Schedule DA treatment. (Refer to the NAIC Annual Statement Instructions.) The factor for other unaffiliated common stock is based on studies that indicate a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock value over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when testing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time loss in fair value occurs.

The total of all unaffiliated common stock reported should be equal to the total value of common stock in Schedule D-Summary by Country C1 L25 less the sum of Schedule D-Summary by Country C1 L24 and PR007, Column 1, Line **18**.

PR008 - Other Long–Term Assets

Real Estate

The Property & Casualty Risk-Based Capital Working Group adopted the factor of 10 percent developed for the Life RBC formula. Encumbrances have been included in the real estate base since the value of the property subject to loss would include encumbrances.

The total book/adjusted carrying value of real estate reported should equal the total of Lines 4.1, 4.2 and 4.3, Column 3 on Page 2 of the annual statement plus the insert amounts on the same lines.

Mortgage Loans on Real Estate

The Property & Casualty Risk-Based Capital Working Group adopted a factor of 5 percent based upon the factors developed by the Life RBC formula, which ranged from 3 percent to 20 percent.

The book/adjusted carrying value of mortgage loans reported should equal Page 2, Line 3.1, Column 3 + Page 2, Line 3.2, Column 3 of the annual statement.

Schedule BA Assets (Other Invested Assets – excluding collateral loans, low income housing tax credits and Working Capital Finance Investments)

Other Invested Assets are those that are listed in Schedule BA and are somewhat more speculative and risky than most other investments. The factor for Schedule BA assets excluding collateral loans is 20%.

The book/adjusted carrying value of total Schedule BA assets (including collateral loans, low income housing tax credits and Working Capital Finance Investments) should equal Page 2, Line 8, Column 3 of the annual statement.

Not for Distribution

Low Income Housing Tax Credits

Report Column (1) in accordance with *SSAP No. 93—Low Income Housing Tax Credit Property Investments*.

Federal Guaranteed low-income housing tax credit (LIHTC) investments are to be included in Line (13). There must be an all-inclusive guarantee from an ARO-rated entity that guarantees the yield on the investment.

Federal Non-guaranteed LIHTC investments with the following risk mitigation factors are to be included in Line (14):

a) A level of leverage below 50 percent. For a LIHTC Fund, the level of leverage is measured at the fund level.
b) There is a tax credit guarantee agreement from general partner or managing member. This agreement requires the general partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC fund, a tax credit guarantee is required from the developers of the lower-tier LIHTC properties to the upper-tier partnership.

State LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (15).

State LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included in Line (16).

State and federal LIHTC investments that do not meet the requirements of lines (13) through (16) would be reported on Line (17).

Working Capital Finance Investments

The book/adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments should equal Note to the Financial Statement, Lines 5M(01a) and 5M(01b), Column 3 of the annual statement.

PR009 - Miscellaneous Assets

Collateral loans and write-ins are generally a small proportion of total portfolio value. A factor of 5 percent is consistent with other risk-based capital formulas studied by the working group.

The factor for cash is 0.3%. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. The 0.3% factor, equivalent to an unaffiliated NAIC 01 bond, reflects the short-term nature of this risk. The required risk-based capital for cash will not be less than zero, even if the company's cash position is negative.

If the book/adjusted carrying value of Aggregate Write-ins for Invested Assets (Page 2, Line 11, Column 3 of the annual statement) is less than zero, the RBC amount will be zero.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3% factor is equal to the factor for cash. The amount entered here should equal the total short-term investments found in Schedule DA Part 1 **C7** L8399999 less bonds that are contained in Schedule D Part 1A Section 1.

Not for Distribution

PR010 - Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities

Basis of Factors

A replication (synthetic asset) transaction is a derivative transaction entered into in conjunction with other investments in order to reproduce the investment characteristics of otherwise permissible investments. A derivative transaction entered into by an insurer as a hedging or income generation transaction shall not be considered a replication (synthetic asset) transaction. All replication transactions must be reviewed and approved by the NAIC Capital Markets & Investment Analysis Office and assigned an RSAT number. The transactions are disclosed in Schedule DB Part C.

A replication (synthetic asset) transaction increases the insurer's exposure to one type of asset, the replicated (synthetic) asset, and may reduce the insurer's exposure to the asset risk associated with the cash market components of the transaction. Both effects are captured and quantified in the worksheet for replication transactions.

A mandatory convertible security is defined as a type of convertible bond that has a required conversion or redemption feature. Either on or before a contractual conversion date, the holder must convert the mandatory convertible security into the underlying common stock. Mandatory convertible securities are subject to special reporting instructions and are therefore not assigned NAIC Designations or Unit Prices by the SVO. The balance sheet amount for mandatory convertible securities shall be reported at the lower of amortized cost or fair value during the period prior to conversion. This reporting method is not impacted by NAIC designation or information received from credit rating providers (CRPs). Upon conversion, these securities will be subject to the accounting guidance of the SSAP that reflects their revised characteristics. For further guidance regarding mandatory convertible securities refer to *SSAP No. 26R - Bonds*. This worksheet adjusts the RBC requirement upward if the security that results from the conversion is more risky than the original security.

Specific Instructions for Application of Formula

This worksheet should contain a line for each replicated (synthetic) asset and each cash instrument component of all replication (synthetic asset) transactions undertaken by the insurer. It should also contain a line for each mandatory convertible security and a line for the security that will result from the conversion. The assets should be sorted first by RSAT number, next by type (replicated assets first, then cash instruments) and finally by CUSIP.

Column (1)
The RSAT number for each transaction should be that used in Schedule DB, Part C, Section 1. Leave this column blank for mandatory convertible securities.

Column (2)
Enter an R (for replicated asset) if the line describes one of the replicated (synthetic) assets, a CW (for cash instrument with RBC credit) if the line describes one of the cash instruments constituting the transaction and the transaction either (1) is a swap of prospectively determined interest rates; or (2) eliminates the asset risk associated with the cash instrument, and a CN (for cash instrument with no RBC credit) if the line describes one of the cash instruments constituting the transaction and the transaction does not eliminate the insurer's exposure to the asset risk associated with the instrument. Enter an MC for a mandatory convertible security and an MCC for the security that will result from the conversion.

Column (3)
Show the CUSIP for all cash instruments that are securities, all mandatory convertible securities and all securities that will result from a mandatory conversion.

Column (4)
Give the description of the replicated (synthetic) asset(s) or cash instruments as found on Schedule DB, Part C, Section 1. Leave blank for mandatory convertible securities.

Column (5)
Give the NAIC designation or other description that will best identify the asset risk designation of the asset. For replications (synthetic assets), this is contained in Column 3 or 14 of Schedule DB, Part C, Section 1.

Not for Distribution

Column (6)
Give the statement value of the asset. For replications (synthetic assets), this is contained in Column 5, 10 or 15 of Schedule DB, Part C, Section 1.

Column (7)
For replicated (synthetic) assets and for the securities that will result from the conversion of a mandatory convertible security, multiply the risk-based capital factor appropriate to the NAIC designation of the replicated (synthetic) asset times the statement value contained in Column (6). For cash instrument components that qualify for a RBC credit and for mandatory convertible securities, the amount contained in this column is the product of:

(a) the risk-based capital factor appropriate to the NAIC designation of the cash instrument or mandatory convertible security, but not higher than the average risk-based capital factor for the replicated (synthetic) asset(s) or the securities that result from the conversion of the mandatory convertible security, times
(b) the statement value contained in Column (6), times
(c) –1

For other cash instrument components, this column should contain zero.

PR011 - Asset Concentration

The purpose of the concentration factor is to reflect the additional risk of high concentrations in single exposures (represented by an issuer of a security or a mortgage borrower, etc.). The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) of the 10 largest asset exposures excluding various low-risk categories or categories which already have a 30 percent factor. Since the risk-based capital of the assets included in the concentration factor has already been counted once in the basic formula, this factor itself only serves to add an additional risk-based capital requirement on these assets.

Concentrated investments in certain types of assets are not expected to represent an additional risk over and above the general risk of the asset itself. Therefore, prior to determining the 10 largest issuers, you should exclude those assets that are exempt from the asset concentration factor. Asset types that are excluded from the calculation include: NAIC 06 bonds, hybrids and preferred stock, affiliated common stock, affiliated preferred stock, property and equipment, U.S. government guaranteed bonds, NAIC 01 bonds, hybrids or preferred stock, any other asset categories with risk-based capital factors less that 1 percent, and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)]. The pro rata share of individual securities within an investment company (mutual fund) or common trust fund are to be included in the determination of concentrated investments, subject to the exclusions identified.

With respect to investment companies (mutual funds) and common trust funds, the reporting company is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the Investment Company Act and provide this information upon request of the commissioner, director or superintendent of the department of insurance. The reporting company is also responsible for maintaining a listing of the individual securities and corresponding book/adjusted carrying values making up its investment companies (mutual funds) and common trust funds portfolio in order to determine whether a concentration charge is necessary. This information should be provided to the commissioner, director or superintendent upon request.

The assets that ARE INCLUDED in the calculation are divided into two categories – Fixed Income Assets and Equity Assets. The following asset types should be aggregated to determine the 10 largest issuers:

FIXED INCOME ASSETS	EQUITY ASSETS
Bonds –NAIC 02	Unaffiliated Preferred Stock –NAIC 02
Bonds –NAIC 03	Unaffiliated Preferred Stock –NAIC 03
Bonds –NAIC 04	Unaffiliated Preferred Stock –NAIC 04
Bonds –NAIC 05	Unaffiliated Preferred Stock –NAIC 05
Collateral Loans	Unaffiliated Hybrid Securities –NAIC 02

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Mortgage Loans
Working Capital Finance Investments – NAIC 02
Federal Guaranteed Low Income Housing Tax Credits
Federal Non-Guaranteed Low Income Housing Tax Credits
State Guaranteed Low Income Housing Tax Credits
State Non-Guaranteed Low Income Housing Tax Credits
All Other Low Income Housing Tax Credits
Unaffiliated Hybrid Securities –NAIC 03
Unaffiliated Hybrid Securities –NAIC 04
Unaffiliated Hybrid Securities –NAIC 05
Unaffiliated Common Stock
Investment Real Estate
Encumbrances on Inv. Real Estate
Schedule BA Assets (excluding Collateral Loans)
Receivable for Securities
Aggr Write-ins for Invested Assets
Derivatives

The name of each of the largest 10 issuers is entered at the top of the table and the appropriate statement amounts are entered in C(2) Ls (01) through (12) for fixed income assets and C(2), Ls (14) through (28) for equity assets. Aggregate all similar asset types before entering the amount in C(2). For instance, if you own five separate $1,000,000 NAIC 03 bonds from Issuer #1, enter $5,000,000 in C(2)L(02) – NAIC 03 Unaffiliated Bonds.

PR012 - Credit Risk for Receivables

Reinsurance Recoverables

The calculation of the credit risk charge for reinsurance recoverables is detailed in Schedule F Part 3 Columns 28 through 36 of the Property/Casualty Annual Statement. This calculation is performed at the transaction level and those results are then summed to determine the charge. Reinsurance balances receivable on reinsurance ceded to non-affiliated companies (excluding certain pools) and to alien affiliates are subject to the credit risk-based capital charge. The following types of cessions are exempt from this charge:

- Cessions to State Mandated Involuntary Pools and Associations or to Federal Insurance Programs.
- This category includes all federal insurance programs [e.g., National Flood Insurance Program (NFIP), Federal Crop Insurance Corporation (FCIC), etc., all state mandated residual market mechanisms and the National Council on Compensation Insurance (NCCI].
- Cessions to U.S. Parents, Subsidiaries and Affiliates.

The categories above are automatically excluded from the data that is **calculated in Schedule F Part 3 of** the Annual Statement.

Since the Annual Statement requires the collectability of reinsurance balances be considered via the reinsurance penalty, the appropriate balances must be offset by any liability that has been established for this purpose. The amount from Page 3, Line 16 should be allocated to the appropriate (re)insurers listed on Schedule F. The total amount recoverable from reinsurers less any applicable reinsurance penalty is multiplied by 120% to stress the recoverable balance. The total of reinsurance payable and/or funds held amounts (not in excess of the stressed recoverable) are applied as offsets to arrive at the stressed net recoverable.

Since there are different reinsurance credit risk factors for collateralized and uncollateralized reinsurance recoverables, the stressed net recoverable should be offset by any available collateral, such as letters of credit, multiple beneficiary trusts, and single beneficiary trusts and other allowable offsets (not in excess of the stressed net recoverable). The collateralized amounts are derived from Schedule F Part 3 Column 32 and the uncollateralized amounts are derived from Column 33.

The risk-based capital for the various credits (including collateral offsets where applicable) taken for reinsurance may not be less than zero even if the amount reported or the amount net of offsets is negative.

The factor for reinsurance recoverables (paid and unpaid less any applicable reinsurance penalty) due from a particular reinsurer is determined based on that reinsurer's financial strength rating assigned on a legal entity basis.

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For the purpose of the credit risk-based capital charge, the equivalent rating category assigned will correspond to current financial strength rating received from an approved rating agency as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. If the reinsurer is unauthorized and does not have at least one financial strength rating, it should be assigned the "Vulnerable 6 or Unrated Unauthorized" equivalent rating. If the reinsurer is authorized and does not have at least one financial strength rating, it should be assigned the "Unrated Authorized Reinsurers" equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the "Secure 3" equivalent rating. An authorized association including incorporated and individual unincorporated underwriters or a member thereof may utilize the lowest financial strength group rating received from an approved rating agency. **The table below shows the R3 reinsurer equivalent rating categories and corresponding factors for A.M. Best, Standard and Poor's, Moody's and Fitch ratings.**

	Reinsurer **Designation** Equivalent Rating Category **and Corresponding Factors**—For RBC R3 Credit Risk Charge						
Description	Secure 1	Secure 2	Secure 3	Secure 4	Secure 5	Vulnerable 6 or Unauthorized Unrated	Unrated Authorized Reinsurers
Best	A++	A+	A	A-	B++, B+	B, B-, C++, C+, C, C-, D, E, F	-------------------------
S&P	AAA	AA+, AA, AA-	A+, A	A-	BBB+, BBB, BBB-	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	-------------------------
Moody's	Aaa	Aa1, Aa2, Aa3	A1, A2	A3	Baa1, Baa2, Baa3	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	------------------------
Fitch	AAA	AA+, AA, AA-	A+, A	A-	BBB+, BBB, BBB-	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	------------------------
Collateralized Amounts Factors	**3.6%**	**4.1%**	**4.8%**	**5.0%**	**5.0%**	**5.0%**	**5.0%**
Uncollateralized Amounts Factors	**3.6%**	**4.1%**	**4.8%**	**5.[illegible]%**	**7.1%**	**14.0%**	**10.0%**

Each reporting company should **record in Schedule F Part 3, Column 34, the reinsurer designation equivalent** financial strength ratings assigned to the (re)insurers listed, where there are balances receivable on reinsurance ceded for the Schedule F categories **subject to the credit risk charge on reinsurance recoverables. The resulting credit risk charge for reinsurance recoverables is determined by applying the corresponding factor by reinsurer designation equivalent to the collateralized and uncollateralized balances respectively. These respective charges are derived from Schedule F Part 3, Columns 35 and 36 and Line 9999999 totals are reported on PR012 Lines 1 and 2.**

Miscellaneous Recoverables

There is risk associated with recoverability of amounts from creditors other than reinsurers. In addition to the default risk, there is the risk that the amounts are not accurately estimated. The factor to measure this risk is estimated at 5 percent for Amounts Receivable Relating to Uninsured Accident and Health Plans; Receivables from Parent, Subsidiaries and Affiliates; and Aggregate Write-ins for Other Than Invested Assets. For Interest, Dividends and Real Estate Income Due and Accrued, which for the most part represents interest income due and accrued from bond holdings, the charge is 1 percent, which is equivalent to the charge applicable to unaffiliated NAIC 02 bonds.

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PR013 - Health Credit Risk

If the reporting entity writes 5 percent or more of its premiums in A&H lines in **2016, 2017 or 2018**, this section of the formula must be completed. To determine if that applies, take the sum of Lines 13, 14, and 15 of the Underwriting and Investment Exhibit Part 1B Column 6 and divide by Line 35 Column 6, and round to three decimals for each individual year. If the result is at least 0.050 in any year, this exhibit and the appropriate Schedule P adjustment must be completed.

If the company writes less than 5 percent of its premiums in A&H lines in **2016, 2017 or 2018**, disregard this section.

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.

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 expense 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 PR021 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 paid to intermediaries is 4 percent of the capitated payments reported as paid claims in PR021 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 PR021 Underwriting Risk – Managed Care Credit Column (2) 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 (1).

Line (3) – Net Capitations to Providers Subject to Credit Risk Charge
Line (1) minus Line (2).

Line (4) – Total Capitation to Intermediaries
From Line (6) and Line (7) of PR021 Underwriting Risk – Managed Care Credit, this includes all capitation payments to intermediaries.

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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 (2) and Figure ([illegible]).

(Figure 1)

Capitations Paid Directly to Providers

Number	Name of Provider	(A) Paid Capitations During Year	(B) Letter of Credit Amount	(C) Funds Withheld	(D) =(B+C)/A Protection Percentage	(E) =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
19999	Total to Providers	3,450,000	xxx	xxx	xxx	800,000

(Figure 2)

Capitations Paid to Un-regulated Intermediaries

Number	Name of Provider	(A) Paid Capitations During Year	(B) Letter of Credit Amount	(C) Funds Withheld	(D) =(B+C)/A Protection Percentage	(E) =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	[illegible],500,000	0	0	0%	0
5	All others	2,[illegible]0,000				0
29999	Total to Unregulated Intermediaries	14,000,000	xxx	xxx	xxx	6,250,000

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(Figure 3)

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 Intermediaries	2,550,000	xxx	xxx	xxx	2,550,000
99999	Total of Figures (1), (2) and (3)	20,000,000	xxx	xxx	xxx	9,600,000

Divide the "Protection Percentage" by 8 percent (providers) or by 16 percent (un-regulated 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 19999 of $800,000 would be reported on Line (2) "Less Secured Capitations to Providers" in PR013 Health Credit Risk. 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 Line (5) "Less Secured Capitations to Intermediaries" in PR013 Health Credit Risk.

Line (9) – Other Medical Costs Paid through ASC Arrangements

ASC is considered to have a separate credit risk related to the use of the company's funds with an expectation of later recovery of all amounts from the contract-holder. Line (9) applies 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.

PR014 - Off-Balance Sheet and Other Items

Off-balance sheet items, such as contingent liabilities, pose a risk to insurers. A 1 percent factor was chosen on a judgment basis to allow for this risk. For securities lending programs, a reduced charge may apply to certain programs that meet the criteria as outlined below.

Specific Instructions for Application of the Formula

Line (1)

Securities lending programs that have all of the following elements are eligible for a lower off-balance sheet charge:

1. A written plan adopted by the Board of Directors that outlines the extent to which the insurer can engage in securities lending activities and how cash collateral received will be invested.
2. Written operational procedures to monitor and control the risk associated with securities lending. Safeguards to be addressed should, at a minimum, provide assurance of the following:
   a. Documented investment guidelines between lender and investment manager with established procedure for review of compliance.
   b. Investment guidelines for cash collateral that clearly delineate liquidity, diversification, credit quality, and average life/duration requirements.
   c. Approved borrower lists and limits to allow for adequate diversification.
   d. Holding excess collateral with margin percentages in line with industry standards which are currently 102% (or 105% for cross currency loans).
   e. Daily mark-to-market of lent securities and obtaining additional collateral needed to maintain margin of 102% of market.
   f. Not subject to any automatic stay in bankruptcy and may be closed out and terminated immediately upon the bankruptcy of any party.

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3. A binding securities lending agreement (standard "Master Securities Lending Agreement" from Securities Industry and Financial Markets Association) in writing between the insurer, or its agent on behalf of the insurer, and the borrowers.
4. Acceptable collateral is defined as cash, cash equivalents, direct obligations of, or securities that are fully guaranteed as to principal and interest by the government of the United States or any agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and NAIC 1 rated securities. Affiliate issued collateral would not be deemed acceptable. In all cases the collateral held must be permitted investments in the state of domicile for the respective insurer.

Collateral included in General Interrogatories Part 1, Line 24.05 of the Annual Statement should be included on Line (1).

<u>Line (2)</u>
Collateral from all other securities lending programs should be reported in General Interrogatories Part 1, Line 24.06 and included in Line (2).

<u>Lines (3) through (14)</u>
Non controlled assets are any assets reported on the balance sheet that are not exclusively under the control of the company, or assets that have been sold or transferred subject to a put option contract currently in force. For Line (12), include assets pledged as collateral reported in the General Interrogatories Part 1, Line 25.30 other than assets related to the Federal Reserve's Term Asset Loan Facility (TALF).

<u>Line (16)</u>
Guarantees for affiliates include guarantees for the benefit of an affiliate which result in a material contingent exposure of the company's assets to liability. The definition of "material" exposure or financial effect is the same as for annual statement disclosure requirements.

<u>Line (17)</u>
Contingent liabilities include any material contingent liabilities that are disclosed in the Notes to Financial Statements. *This category includes all structured securities for which the company has not received a full release from liability from a third party.*

<u>Line (18)</u>
"Yes" means the entity which files the U.S. Federal income tax return which includes the reporting entity is a regulated insurance company (including where the reporting entity is the direct filer of the tax return). "No" means the entity which files the US federal income tax return which includes the reporting entity is not a regulated insurance company (e.g. a non-insurance entity or holding company makes the filing). "N/A" means the entity is exempt from filing a US federal income tax return; lines (16) and (17) should be zero in this case.

<u>Lines (19) and (20)</u>
Apply a one-percent (1%) charge in the RBC formula, placed outside of the covariance adjustment, to admitted adjusted gross deferred tax assets (DTAs) as described in SSAP No. 101, paragraphs 11a and 11b (lesser of paragraph 11b(i) and 11b(ii)). For the period for which the paragraph 11a component is determined, the charge is reduced to one-half percent (0.5%) when the insurance company either filed its own separate Federal income tax return or it was included in a consolidated Federal income tax of which the common parent is an insurance company. The source for the DTA amounts to use in the calculation is found in the Annual Statement, Notes to Financial Statements, Note 9, Part A, Section 2, Admission Calculation Components for *SSAP No. 101 – Income Taxes*. Paragraph 11a is found in Section 2, subpart (a). Paragraph 11b is found in Section 2, subpart (b).

Not for Distribution

OFF-BALANCE SHEET COLLATERAL AND SCHEDULE DL, PART 1 ASSETS
PR015

Security lending programs are required to maintain collateral. Some entities post the collateral supporting security lending programs on their financial statements, and incur the related risk charges on those assets. Other entities have collateral that is not recorded on their financial statements. While not recorded on the financial statements of the company, such collateral has risks that are not otherwise captured in the RBC formula.

The collateral in these accounts is maintained by a third party (typically a bank or other agent). The collateral agent maintains on behalf of the company detail asset listings of the collateral assets, and this data is the source for preparation of this schedule. The company should maintain such asset listings, at a minimum CUSIP, market value, book/carrying value, and maturity date.

The asset risk charges are derived from existing RBC factors for bonds, preferred and common stocks, other invested assets, and invested assets not otherwise classified (aggregate write-ins).

Specific Instructions for Application of the Formula

Column (2) – Schedule DL, Part 1 Book/Adjusted Carrying Value comes from Annual Statement Schedule DL, Part 1, Column (6) Securities Lending Collateral Assets reported On-Balance Sheet (Assets Page, Line 10).

Off-balance sheet collateral included in General Interrogatories Part 1, Lines 24.05 and 24.06 of the Annual Statement should agree with Line (22), Column (1).

Lines (1) through (9) – Bonds
Bond factors described on PR006 – Unaffiliated Bonds and Bond Size Factor Adjustment

Line (10) through (16) – Preferred Stocks
Preferred stock factors described on PR007 – Unaffiliated Preferred and Common Stock

Lines (17) – Common Stock
Common stock factors described on PR007 – Unaffiliated Preferred and Common Stock

Line (18) – Real Estate and Schedule BA - Other Invested Assets
Real Estate and other invested asset factors described on PR008 – Other Long-Term Assets

Line (19) – Other Invested Assets
Other invested assets factors described on PR009 – Miscellaneous Assets

Line (20) – Mortgage Loans on Real Estate
Mortgage Loans on Real Estate factor described on PR009 – Miscellaneous Assets

Line (21) – Cash, Cash Equivalents, Non-Government Money Market Fund and Short-Term Investments
Cash, Cash Equivalents, Non-Government Money Market Fund and Short-Term Investments factors described on PR007 – Unaffiliated Preferred, Common Stock and Hybrid Securities and PR009 – Miscellaneous Assets

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EXCESSIVE PREMIUM GROWTH
PR016

Studies have shown that rapidly growing companies tend to have larger reserve deficiencies than other insurers with more normal growth. Companies with an average annual premium growth rate of more than 10 percent will be charged with additional risk-based capital to reflect this additional risk. For members of a group, the growth rate is based on a group growth rate rather than the individual member's growth rate. A group consists of all Property and Casualty companies with the same NAIC Group Code number. Enter four years of group gross written premiums for the current year group code even though the reporting company was not part of the group for all years. If the reporting company is not a member of a group, the premium to be entered is the premium of the individual company. Enter both company written premiums and group written premiums if the reporting company is a member of a group.

Servicing Carriers may exclude Gross Written Premiums from involuntary pool business from the Group Gross Written Premium. In the context of residual markets and/or assigned-risk business, a servicing carrier is a licensed insurer that, either through a competitive bid process or by virtue of a state appointment, administers the business. Such administration may include policy issuance, billing and collection, rating, fraud control, medical management and claim payment. In general, the accounts are written on the servicing carriers paper; however, the results are pooled and distributed to all licensed companies (for that particular line of business) in the state, that are assessed by market share. The servicing carrier is paid a fee for the administrative services it provides. If the company for which this report is being prepared is part of a group of companies, enter the group adjustments in Column (4); otherwise, enter the individual company adjustments in Column (2). DO NOT DEDUCT PARTICIPATION IN RESIDUAL MARKET MECHANISMS. However, an adjustment is required for carriers that are servicing carriers for an assigned risk mechanism. Those carriers shall exclude gross written premiums from involuntary pool business for any of those years. That adjustment for the company and for the group must be entered on the appropriate line in the program.

The growth rate used in this calculation is a three-year average growth rate of gross written premiums. Gross written premiums are direct written premiums plus written premiums assumed from non-affiliates and are calculated from the Underwriting and Investment Exhibit Part 1B as the sum of Column 1, Line 35 plus Column 3, Line 35. The four most recent years of data are required to compute the growth rate. However, an adjustment is allowed for carriers which are servicing carriers for an assigned risk mechanism. Those carriers may exclude gross written premiums from involuntary pool business for any of those years. That adjustment for the company and for the group must be entered on the appropriate lines in the program.

In determining the gross written premium, all years of gross written premium should be included for any P&C affiliate that was acquired during the four-year period. Similarly, all years of gross written premium should be excluded for any P&C affiliate that was divested during the four-year period. The exception to this rule applies to a P&C affiliate acquired without the parent assuming any of the affiliate's liability obligations (i.e., the parent acquired a "shell" company). In that case, the gross written premiums of the acquired insurer(s) should be excluded. Similarly, if a P&C affiliate is divested but the parent retains the affiliate's liability obligations (that is, the parent divested a "shell" company), then the gross written premiums of that affiliate should remain in the parent's group gross written premiums.

When the data necessary to calculate a three-year average growth rate is not available, a two-year average growth rate should be calculated using the latest three years of premiums. If only the most recent two years of gross written premiums are available, then a one year average growth rate should be calculated. If the company has no gross written premiums in the latest year, then the growth rate will be set to zero. A default growth rate of 40 percent is used in the first year for a start-up company.

Each individual year's growth rate is capped at 40 percent. The Selected Average Growth Rate is the average of individual years' growth rates. The excess of the growth rate over 10 percent is the RBC Average Growth Rate Factor. This factor is multiplied by 0.45 to determine the excessive growth charge factor for loss and expense reserves and by .225 to determine the excessive growth charge factor for written premiums. The total amount of loss & expense reserves from Schedule P Part 1–Summary C24 L12 is multiplied by 1,000 to bring it up to whole dollars, and this amount is entered on the appropriate line on the RBC filing software to calculate the required RBC for excessive growth. The total net written premiums from the Underwriting and Investment Exhibit Part 1B L35 C6 are entered on the appropriate line to calculate the excessive growth for net written premiums.

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UNDERWRITING RISK
PR017 – PR018

Underwriting risk is the largest portion of the risk-based capital charge for most property casualty insurance companies and makes up approximately 55 percent of the aggregate industry risk-based capital prior to the covariance adjustment. Underwriting risk is broken into two components in the RBC formula: the RBC charge calculated for reserves and the RBC charge applied against written premiums.

The reserve risk RBC is developed by multiplying a set of RBC factors, which are discounted for investment income and adjusted for each individual company's own relative experience, times the gross of non-tabular discount net reserves for each of 19 major lines of business. A set of credits is available to these by-line RBC charges for loss-sensitive business. The aggregate reserve risk RBC is then adjusted to allow a credit for the amount of diversification among the 19 lines of business.

The 19 major lines of business largely correspond to the major breakdowns in Schedule P of the annual statement. Calculations for some lines are combined: the occurrence form and claims made form of Other Liability (H1 and H2) are combined; the occurrence form and claims made form of Products Liability (R1 and R2) are combined; and Reinsurance - Property and Reinsurance – Financial Lines (N and P) are combined.

Those lines used in the calculation and the applicable subsections of Schedule P are: Homeowners/Farmowners Multi-Peril (A); Private Passenger Auto Liability and Medical Payments (B); Commercial Auto Liability (C); Workers Compensation (D); Commercial Multi-Peril (E); Medical Professional Liability-Occurrence (F-Section 1); Medical Professional Liability-Claims Made combined (F–Section 2); Special Liability (G); Other Liability–Occurrence and Other Liability–Claims Made combined (H–Section 1 and H–Section 2); Special Property (I); Auto Physical Damage (J); Other (Including Credit, Accident and Health) (L); Financial Guaranty/Mortgage Guaranty (S); Fidelity Surety (K); International (M); Reinsurance A and Reinsurance C (N and P); Reinsurance B (O); Products Liability–Occurrence; Products Liability–Claims Made combined (R–Section 1 and R–Section 2) and Warranty (T).

For any company that writes 5 percent or more of its business in the three accident and health lines (Group A&H, Credit A&H, and Other A&H) in the current year, or either of the two immediately preceding years, a separate calculation for health RBC is mandated, based on the life RBC formula.

The written premium RBC is developed by multiplying a factor times the current year's net written premiums, which are also broken down by line. The RBC factor for each line is based on the excess of a discounted combined ratio adjusted for investment income over 100 percent. As with the reserve risk factors, individual company experience is also considered in computing the RBC factor.

<u>PR017 - Underwriting Risk – Reserves</u>

<u>Line 01 – Industry Average Development</u> – The factors for each line of business are provided by the NAIC and are shown on Line 01 of the Underwriting Risk-Based Capital Summary. These factors are based on the average loss and defense and cost containment expense reserve development of all reporting companies over the past nine years.

<u>Line 02 – Company Development</u> – For each line of business, the company development factor is defined as the ratio of the sum of the developed incurred losses and defense and cost containment expenses from prior accident years evaluated as of the current year to the sum of the initial evaluations of these incurred losses and defense and cost containment expenses. The company development factor is capped at 400 percent so that insurers are not unduly penalized for anomalous results. The calculation uses nine accident years for all lines of business. Reinsurance for Property line and Reinsurance for Financial line are combined before computing the company Development factor.

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In some instances, the company is not allowed to use its own experience to adjust the industry loss and expense RBC factor. When any of the following conditions are true, then the company must set its company average development factor equal to the industry average development factor (i.e., Row 02 = Row 01):

1. The current incurred (Schedule P, Part 2, Column 10) for any accident year is less than or equal to zero; or
2. The initial incurred for any accident year (Schedule P, Part 2, along the diagonal) is negative; or
3. The sum of the initial incurred estimates is zero.

Line 03 is the ratio of Line 02 to Line 01. If the company is required to use the industry average experience (Row 02 = Row 01), this line is set at 1.000.

Line 04 – Industry Loss & Expense RBC Percent – These factors are designed to provide a surplus cushion against adverse reserve development. They are based on detailed analysis of historical reserve development patterns found in Parts 2 and 3 of Schedule P for each major line of business. The factors are provided by the NAIC and are shown on the Underwriting RBC Summary by line of business. NOTE: the factors are based on analysis of the combined data for Other Liability, Reinsurance for Property and for Financial Lines and Products Liability.

Line 05 – Company RBC Percent – This percentage is an equally weighted average of (a) the Industry Loss and Expense RBC percent in Line 04 adjusted by the Company Development to Industry Average Development Factor in Line 03 and (b) the Industry Loss and Expense RBC percent in Line 04. By using an equally weighted average, a measure of credibility is introduced to balance the company's experience with what would be considered "normal" for the industry.

Line 06 – Loss & Loss Adjustment Expense Unpaid – This is the net loss and loss adjustment expense unpaid by line of business from Schedule P, Part 1, Column 24.

Line 07 – Other Discount Amounts Not Included in Loss & Loss Adjustment Expense Unpaid in Schedule P, Part 1 – The numbers reported in Schedule P, Part 1, Column 24 are supposed to be gross of discounts. However, in some instances in some lines, insurers are allowed to report their reserves net of tabular medical discounts. Non-tabular discounts are reported separately in Column 32 and Column 33 of Schedule P, Part 1, and the amount reflected in Column 24 should already be gross of those amounts. If an insurer's Column 24 reserves are net of any non-tabular discounts, those discount amounts should be in the appropriate field on the RBC software.

Line 08 – Adjustment for Investment Income – This discount factor assumes a 5 percent interest rate. For lines of business other than workers' compensation and the excess reinsurance lines, the payment pattern is determined using an IRS type methodology applied to industry-wide Schedule P data by line of business; otherwise, a curve has been fit to the data to estimate the average payout over time. The discount factor for workers' compensation is adjusted to reflect the tabular portion of the reserves that is already discounted. The factors are provided by the NAIC and are shown on the Underwriting RBC Summary by line of business.

Line 09 – Base Loss & Loss Adjustment Expense Reserve Risk-Based Capital – This represents the base required reserve capital after recognition of the time value of money in held undiscounted reserves but before the application of discounts for loss-sensitive business and business spread. If the gross reserves (Line 06 plus Line 07) are negative, then the RBC charge is set at zero.

Line 10 – Percent Loss Sensitive Direct – A 30 percent discount to the Line 09 Base Loss and Expense RBC is allowed for loss-sensitive business that has been written directly. The by-line percentage found in Schedule P, Part 7A, Section 1, Column 3 is pulled via the vendor link or may be manually entered on the RBC software (for combined lines, the weighted average is used).

Line 11 – Percent Loss Sensitive Assumed – A 15 percent discount to the Line 09 Base Loss and Expense RBC is allowed for loss-sensitive business that has been assumed. The by-line percentage found in Schedule P, Part 7B, Section 1, Column 3 is pulled via the vendor link or manually entered on the RBC software (for combined lines, the weighted average is used).

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Line 12 – Loss Sensitive Discount – This is the total discount for loss sensitive business, computed as [L(09) x .30 x L(10) + L(09) x .15 x L(11)]. Prior to the calculation, L(10) and L(11) are both capped at 100 percent. If L(10) or L(11) is negative, then that line is set to zero prior to the calculation of the total loss sensitive discount.

Line 13 – Loss & Loss Adjustment Expense RBC After Discounts – Calculated as L(09) – L(12).

Line 14 – Loss Concentration Factor – A discount for spread of business is applied to the total Loss and Expense RBC After Discounts in C(16) L(13). This reflects the fact that a diversified portfolio of insurance is not likely to experience poor results in all lines simultaneously. The Loss Concentration Factor (LCF) is calculated from the separate Schedule P lines. When determining the largest line, claims-made and occurrence (Other Liability and Products Liability) loss and expense reserves should be combined. To calculate the LCF, the reserve for the largest line in Schedule P is divided by the total reserves in Schedule P, Part 1 Summary, and that amount is multiplied by 0.300 and then added to 0.700. If a company only writes one line of business, the ratio of that single line to the total reserves is 1.000 and the calculated LCF is also 1.000 [(1.000 x 0.300) + 0.700 = 1.000]. If a company's largest line of business makes up half of its total reserves, the calculation is [(0.500 x 0.300) + 0.700 = 0.850]. In this second example, the company would receive a discount of 15 percent to its Loss and Expense RBC After Discounts.

Line 15 –Total Net Reserve RBC – L(13) x L(14) x 1,000. Since the numbers in Schedule P are presented in 000's, the result here must be multiplied by 1,000 to bring it to whole dollars.

PR018 - Underwriting Risk – Net Written Premiums

Line 01 – Industry Average Loss & Loss Adjustment Expense Ratio – These factors are provided by the NAIC and are shown on the Underwriting RBC Summary by line of business. The factors are based on the historical experience of companies reporting to the NAIC and represent virtually all of the property casualty industry's loss experience.

Line 02 – Company Average Loss and Loss Adjustment Expense Ratio – For each line of business, this is defined as a straight average of a company's accident year loss and expense ratios. For the **2017** annual statement, the most recent 10 accident years (**2009 to 2018**) are used for all lines. Reinsurance for Property line and Reinsurance for Financial line are combined before computing the Company Average Loss and Expense Ratio.

The company average loss and expense ratio is set equal to the industry average loss and expense ratio (i.e., Row 02 = Row 01) if any of the following conditions is true:

1) The loss and expense ratio for any accident year is zero or negative;
2) The net earned premium for any accident year is zero or negative.

Otherwise, the company average loss and expense ratio is calculated subject to a de minimus test. The de minimus test is intended to avoid unusual loss and expense ratios produced in years with low premium volumes. The procedure is:

> For each line, calculate the average net earned premium for the available years. If more than two years' net earned premium is less than 20 percent of the average net earned premium, a company is not eligible for an experience adjustment and Row 02 is set equal to Row 01. Otherwise, a company must exclude years where the net earned premium is less than 20 percent of the average net earned premium and take a straight average of the loss and expense ratios of the remaining years. In addition, each accident year loss and expense ratio must be capped at 300 percent before calculating the straight average.

Line 03 is the ratio of Line 02 to Line 01. If the company is required to use the industry average experience (Row 02 = Row 01), this line is set at 1.000.

Line 04 – Industry Losses & Loss Adjustment Expense Ratio – The industry RBC loss and expense ratio factors are provided by the NAIC and shown on the Underwriting RBC Summary for each line of business.

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Line 05 – Company RBC Losses & Loss Adjustment Expense Ratio – This ratio is an equally weighted average of (a) the Industry RBC Loss and Expense Ratio adjusted by the Company to Industry Ratio; and (b) the Industry RBC Loss and Expense Ratio.

Line 06 – Company Underwriting Expense Ratio – This is the ratio of other underwriting expense incurred found in the annual statement on P4 C1 L4 to total net written premium for the current year found in the Underwriting and Investment Exhibit Part 1B L35 C6. If the ratio is negative, it is reset to zero. Also, the ratio is capped so that it cannot exceed 400 percent.

Line 07 – Adjustment for Investment Income – This discount factor assumes a 5 percent interest rate. For lines of business other than workers' compensation and the excess reinsurance lines, the payment pattern is determined using an IRS-type methodology applied to industry-wide Schedule P data by line of business. For the workers' compensation and the excess reinsurance lines, the payment patterns were determined by fitting a curve to the data. Workers' compensation is adjusted to reflect the tabular portion of the reserves that is already discounted. These factors are provided by the NAIC and are shown on the Underwriting RBC Summary by line of business.

Line 08 – Net Written Premium – This is the current year net written premium from the Underwriting and Investment Exhibit–Part 1B in thousands of dollars, by line of business. The net written premium of Aggregate Write-ins for Other Lines of Business (Line 35) will be included in the Other Liability line. NOTE: Net Written Premium is reported in whole dollars in the UIEX1B, but is calculated in 000's by the Underwriting Risk – NWP.

Line 09 – Base Written Premium Risk-Based Capital – The company risk-based capital loss and expense ratio is adjusted for investment income and added to the company underwriting expense ratio. The excess of this result over 100 percent is applied to the company's current year net written premium to determine the Base Net Written Premium RBC prior to discounts being applied.

Line 10 – Percent Loss Sensitive Direct NWP– A 30 percent discount to the Line (09) Base NWP RBC is allowed for loss-sensitive business that has been written directly. The by-line percentage found in Schedule P, Part 7A, Section 1, Column 6 will be pulled via the vendor link or may be manually entered (for combined lines, the weighted average is used).

Line 11 – Percent Loss Sensitive Assumed NWP – A 15 percent discount to the Line (09) Base NWP RBC is allowed for loss-sensitive business that has been assumed. The by-line percentage found in Schedule P, Part 7B, Section 1, Column 6 will be pulled via the vendor link or may be manually entered (for combined lines, the weighted average is used).

Line 12 – Loss Sensitive Discount for NWP – This is the total discount for loss sensitive business, computed as [L(09) x 0.30 x L(10) + L(09) x 0.15 x L(11)]. Prior to the calculation, L(10) and L(11) are both capped at 100 percent. If L(10) or L(11) is negative, then that line is set to zero prior to the calculation of the total loss sensitive discount.

Line 13 – NWP RBC After Discounts – Calculated as L(09) – L(12).

Line 14 – Premium Concentration Factor – A discount for spread of business is applied to the total NWP RBC After Discounts in C(20) L(13). This reflects the fact that a diversified portfolio of insurance is not likely to experience poor results in all lines simultaneously. The Premium Concentration Factor (PCF) is calculated from the separate Schedule P lines. When determining the largest line, claims-made and occurrence (Other Liability and Products Liability) net written premiums should be combined. To calculate the PCF, the NWP for the largest line in Schedule P is divided by the total NWP from the Underwriting and Investment Exhibit Part 1B, Line 35, Column 6, and this amount is multiplied by 0.300 and then added to 0.700. If a company only writes one line of business, the ratio of that single line to the total NWP is 1.000 and the calculated PCF is also 1.000 [(1.000 x 0.300) + 0.700 = 1.000]. If a company's largest line of business makes up one-fourth of its total NWP, the calculation is [(0.250 x 0.300) + 0.700 = 0.775]. In this second example, the company would receive a discount of 22.5 percent to its NWP RBC After Discounts.

Line 15 – Total NWP RBC – L(13) x L(14) x 1,000. Since the results in the RBC table are calculated in 000s, the result must be multiplied by 1,000 to bring it to whole dollars.

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LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS
PR019 – PR026

If the reporting company writes 5 percent or more of its premiums in A&H lines in **2016**, **2017** or **2018**, this section of the formula must be completed. To determine if that applies, take the sum of Lines 13, 14 and 15 of the Underwriting and Investment Exhibit Part 1B Column 6 and divide by Line 35 Column 6, and round to three decimals for each individual year. If the result is at least 0.050 in any year, this exhibit and the appropriate Schedule P adjustment must be completed.

If the company writes less than 5 percent of its premiums in A&H lines in **2016**, **2017** and **2018**, disregard this section.

PR019 - Health Premiums

Basis of Factors

Risk-based capital factors for health insurance are applied to medical, disability income, long-term care insurance and other types of health insurance premiums and claim reserves with an offset for premium stabilization reserves. For health coverage that 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 categories for individual coverages and 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 1999 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, Dental & Vision business, or Stand-Alone 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 PR021 Underwriting Risk – Managed Care Credit. Appendix 1 - Commonly Used Health Insurance Terms has been added to these instructions. Appendix 2 of these instructions lists commonly used terms of Stand-Alone Medicare Part D coverage. If the company has any of the three mentioned types of medical insurance, it will also be required to complete additional parts of the formula for Health Credit Risk (PR013) and Health Administrative Expenses portion in PR022.

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.

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.

Specific Instructions for Application of the Formula

The total of all earned premium categories in PR019 Health Premiums, Line (26), Column (1) should equal the total in Schedule H, Part 1, 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 Contract (ASC) and/or the Federal Employees Health Benefit Program (FEHBP) which are included in order that Line (26) will equal the total in Schedule H. As such, there is no RBC factor

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applied to any premium reported on lines (14), (23) or (24). 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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (1) Line (1.1). **Medicaid Pass-Through Payments reported as premium in the annual statement filing should be excluded from the premium amounts reported in Line 1 and reported in Line (3.3) and (10.3), respectively.**

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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, 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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.1).

Line (3.1)
Health incurred claims for Stand-Alone 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 2 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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.1).

Line (3.2)
Health incurred claims for Supplemental benefits within Stand-Alone 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 Stand-Alone Medicare Part D Coverage on PR019.

Line (3.3)
Medicaid pass-through payments reported as premium and excluded from Line (1) should be reported in Line (3.3).

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)
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. The maximum amount of retained risk for any single claim;
2. $300,000 if three 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.

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There are places for reporting the total amount of earned premium and the maximum retained risk on any single claim. The actual RBC amount 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)
A 5 percent 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 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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, 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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.2).

Line (9)
The American Academy of Actuaries submitted a report to the Health Risk-Based Capital 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 Medical. 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 Medical. 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 the premium in excess of $25,000,000.

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 PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (2) Line (1.2).

Line (10.1)
Health premium for Stand-Alone 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 2 for definition of these terms. Stand-Alone Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (25) Other Health. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (9). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.2).

Line (10.2)
Health Incurred Claims for Supplemental benefits within Stand-Alone 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 lesser 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 PR019.

Line (10.3)
Medicaid pass-through payments reported as premium and excluded from Line (1) should be reported in Line (10.3).

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Lines (15) through (24)

Disability income premiums are to be separately entered depending on 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). For long-term care insurance, premiums are reported separately for Individual noncancellable, Individual (other than NC) and Group LTCI. 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. For long-term care, all types (Individual and Group) are combined.

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.

	Disability Income Premium	Annual Statement Source	Statement Value	Factor	RBC Requirement
Line (15)	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	______	X 0.350 =	______
b)	Over $50 Million Earned Premium of Line (15)	Company Records	______	X 0.150 =	______
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (15) + b) of Line (15), Column (2)			______
Line (16)	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 0.250 =	______
b)	Earned Premium in Line (16) not included in a) of Line (16)	Company Records	______	X 0.070 =	______
c)	Total Other Disability Income - Individual Morbidity	a) of Line (16) + b) of Line (16), Column (2)			______
Line (17)	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 0.200 =	______
b)	Over $50 Million Earned Premium of Line (17)	Company Records	______	X 0.030 =	______
c)	Total Disability Income - Credit Monthly Balance	a) of Line (17) + b) of Line (17), Column (2)	______		______
Line (18)	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 0.150 =	______
b)	Earned Premium in Line (18) not included in a) of	Company Records	______	X 0.030 =	______

Not for Distribution

			Annual Statement Source	Statement Value	Factor	RBC Requirement
		Disability Income Premium Line (18)				
	c)	Total Disability Income – Group Long Term	a) of Line (18) + b) of Line (18), Column (2)	________		
Line (19)		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	PR019 Health Premiums Column (1) Line (27)	________		
	b)	Additional Reserves for Credit Disability Plans, Prior Year	PR019 Health Premiums Column (1) Line (28)	________		
	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 0.100 =	________
	e)	Earned Premium in c) of Line (19) not included in d) of Line (19)	Company Records	________	X 0.030 =	________
	f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (19) + e) of Line (19), Column (2)			________
Line (20)		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 0.150 =	________
	b)	Earned Premium in Line (20) not included in a) of Line (20)	Company Records	________	X 0.030 =	________
	c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (20) + b) of Line (20), Column (2)	________		________
Line (21)		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 0.050 =	________
	b)	Earned Premium in Line (21) not included in a) of Line (21)	Company Records	________	X 0.030 =	________
	c)	Total Disability Income – Group Short Term	a) of Line (21) + b) of Line (21), Column (2)	________		________
Line (22)		Noncancellable Long-Term Care Premium – Rate risk	Earned Premium (Schedule H, Part 1, Line 2, in part)	________	X 0.100 =	________

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Line (25)
Most Health Premium will have been included in one of the prior lines. In the event that some coverage does not fit into any of these categories, "Other Health" category is applied with a 12% factor, which is from 1998 formula for Other Limited Benefits Anticipating Rate Increases.

Stop Loss Electronic Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2018, will reflect the incurred data for calendar year 2017 run-out through December 31st, 2018.

For those insurers where the stop loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.
Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.
HMO Reinsurance = specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
Medical Excess Reinsurance = specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for 2018 should provide experience information for calendar year 2017 with run-out through December 31, 2018.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

> **Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.** .
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Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2 – Calendar Year Stop Loss Contracts By Group Size

For those insurers where the stop loss gross premium written is both under $2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, employees plus dependents).

Number of Groups – list the number of groups for each stop loss contract based on the number of covered lives in the group.

Average Specific Attachment Point - The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Average Aggregate Attachment Percentage – Is based on expected claims. Subgroups of groups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

PR020 - Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental and Vision

(Underwriting Risk – Experience Fluctuation Factor in the LRBC Formula)

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 PR021 Underwriting Risk - Managed Care Credit.

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Description from *Life Risk-Based Capital Report Including Overview & Instructions*:

> 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 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) of PR021 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 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 dental coverage and six times the maximum or $1,500,000 for Stand-Alone Medicare Part D coverage.

Line (1) through Line (18)

There are four lines of business used in the property/casualty RBC formula for calculating the RBC requirement in this worksheet. Other health coverages will continue to use the factors on PR019 Health Premiums. The four lines of business are Column (1) Comprehensive Medical and Hospital; Column (2) Medicare Supplement Column (3) Dental & Vision and Column (4) Stand-Alone Medicare Part D coverage. Each of the four lines of business has its own column in the Underwriting Risk – Premium Risk table. The categories listed in the columns of this worksheet include premiums plus all risk revenue that is received from another health entity in exchange for medical services provided to such Health entity's members. The descriptions of the items are 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, or any non-underwritten business. These programs are reported in PR022 Underwriting Risk – Other, Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Program (FEHBP) business, which is reported on Line (3) of PR022 Underwriting Risk – Other. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000.

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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 vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Stand-Alone Medicare Part D Coverage
Includes policies and contracts providing the standard coverage for individuals enrolled in Stand-Alone 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 Stand-Alone 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 PR019 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 PR022 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 Stand-Alone Medicare Part D Coverage, this will include only certain amounts paid by the individual, an employer or CMS. See Appendix 2 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 Stand-Alone Medicare Part D coverage under the low-income subsidy (cost sharing portion) and low-income subsidy (premium portion) are not included in this line.

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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 health insurance company (Health). 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 insurance company 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 an health 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. This line does not include ASC payments or Federal Employees Health Benefit Program (FEHBP) claims.

Column (1) claims come from Annual Statement, Schedule H, Part 5 Column 1 Line D13 less the amounts reported as incurred claims for Administrative Services Contracts (ASC) in Line (8) of PR013 and Federal Employee Health Benefit Plan (FEHBP) in Line (3) of PR022. (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) claims come from General Interrogatories Part 2, Line 1.5. Column (3) dental claims come from Schedule H, Part 5, Column 2, Line D13.)

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined 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 or charges to nonmember/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.

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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 & Vision	0.120	0.076	0.076
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151

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 (12) of PR021 Underwriting Risk - Managed Care Credit. 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 (12) of PR021 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 between 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.

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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 =	$100,000	deductible
	+$150,000	($750,000 - $600,000)
	+$50,000	(10% of $500,000 coverage layer)
	=$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 =	$75,000	deductible
	+$0	($750,000 - $1,075,000)
	+$67,500	(10% of $675,000 coverage layer)
	=$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 Medicare Supplement and Dental. Six times the amount in Line (15), subject to maximum of $150,000 for Stand-Alone 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).

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

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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 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 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 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 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 – 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) 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 ensure that true risk transfer is accomplished.

<u>Line (1)</u>
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 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 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.

<u>Line (2)</u>
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, diagnosis 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.

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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 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 made directly to licensed providers.

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

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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 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 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 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. When 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 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

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services; and (2) there are mutual unlimited guarantees of solvency between the entity and the health plan, that put their respective capital and surplus at risk in guaranteeing each other.

Line (10.1)
Category 0 for Stand-Alone Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (10.2)
Category 1 for Stand-Alone 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 (10.3)
Category 2a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (10.4)
Category 3a for Stand-Alone Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (10.6)
Total Paid Claims – The total of Column (1) paid claims should equal the total claims paid for the year as reported in Schedule H, Part 5, Columns 1 and 2, Line D16 of the annual statement.

Line (11)
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 (12)
Weighted Average Managed Care Risk Adjustment Factor - This is the credit factor that is carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount (Line (11)).

Lines (13) through (19)
Lines (13) through (19) 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 (13)
Enter the prior year's actual withhold and bonus payments.

Line (14)
Enter the prior year's withholds and bonuses that were available for payment in the prior year.

Line (15)
Divides Line (13) by Line (14) to determine the portion of withholds and bonuses that were actually returned in the prior year.

Line (16)
Equal to Line (14) and is automatically pulled forward.

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Line (17)
Claims payments that were subject to withholds and bonuses in the prior year. Equal to Line (3) + Line (4) of Underwriting Risk–Managed Care Credit FOR THE PRIOR YEAR.

Line (18)
Divides Line (16) by Line (17) to determine the average withhold rate for the prior year.

Line (19)
Multiplies Line (15) by Line (18) 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.

PR022 - Underwriting Risk – Other and Total Net Health Premium RBC

Administrative Expenses for Certain A&H Coverages and for Health ASO/ASC

To maintain general consistency with the life 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 service 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.

Specific Instructions for Application of the Formula

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 that include a medical trend risk; i.e. Comprehensive Medical, Medicare Supplement, Dental and Vision, Stand-Alone 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.

Line (8)
Enter the total amount of administrative expenses for health insurance in Column (1) – this amount will come from company records. Lines (9) and (10) are used to back out any amounts related to Administrative Services Contracts (ASC) and Administrative Services Only (ASO) contracts, respectively – these are brought back into the formula in Lines (15) and (16). Line (11) backs out administrative expenses for commissions and premium taxes.

Line (15)
Include the amount reported in Line (9) plus any other administrative expenses for ASC business. Line (15) should be greater than or equal to Line (9).

Line (16)
Include the amount reported in Line (10) plus any other administrative expenses for ASO business. Line (16) should be greater than or equal to Line (10).

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