NAIC
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2017

RBC
Risk-Based Capital

FORECASTING
& INSTRUCTIONS

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NAIC
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Risk-Based Capital Forecasting & Instructions

Health

2017

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National Association of Insurance Commissioners

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NAIC Health Risk-Based Capital Newsletter

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What RBC Pages Should Be Submitted?

For the year-end 2017 health risk-based capital (RBC) filing, submit hard copies of pages **XR001 through XR027** to any state that requests a hard copy in addition to the electronic filing. Beginning with year-end 2007, a hard copy of the RBC filings was not required to be submitted to the NAIC. Other pages, such as the capitations worksheet, do not need to be submitted. Those pages would need to be retained by the company as documentation.

Business Risk—Excessive Growth Charge For Start-Up Companies

As a result of the adoption of agenda item 2014-28-H (MOD) by the Capital Adequacy (E) Task Force at the 2016 Fall National Meeting, new footnotes were added to page XR021 for the use of projected amounts in prior year Line (13) and Line (15), along with an explanation of the projections used.

Money Market Mutual Funds

As a result of the reclassification of money market mutual funds (MMMFs) to cash equivalents by the Statutory Accounting Principles (E) Working Group, the Capital Adequacy (E) Task Force adopted agenda item 2016-15-CA at the Spring National Meeting. MMMFs will be isolated on their own line under the Miscellaneous Fixed Income Assets section on page XR007 and subtracted from the cash equivalents. The Annual Statement Source will be Schedule E, Part 2, Column 7, Line 8599999.

In This Issue:

Operational Risk

As a result of a technical issue that was presented during the June 28 Capital Adequacy (E) Task Force conference call, implementation of a risk factor for Operational Risk has been deferred for at least a year. The Task Force adopted agenda item 2016-13-O at the Spring National Meeting and modified it on its June 28 conference call. At the Spring National Meeting, the Task Force in essence voted to "go live" for 2017 reporting by adopting the structural change to remove the basic operational risk options from the informational-only page but retain the growth risk portion in the informational only page, and move the "add-on" approach for basic operational risk to Page XR025. On its June 28 conference call, the Task Force adopted the operational risk instructions for pages XR002, XR022 and XR024-XR025, but voted to reduce the recommended RBC charge from 1.5% to 0% for 2017 to allow the Operational Risk (E) Subgroup to address the technical concerns raised.

Supplemental Benefits within Stand-Alone Medicare Part D Coverage

As a result of the adoption of agenda item 2016-16-CA by the Capital Adequacy (E) Task Force at the Spring National Meeting, the factor for Supplemental Benefits within Stand-Alone Medicare Part D Coverage (Page XR014, Line (22.1)) was increased to 0.500 and will be applied to claims incurred.

Stop Loss

As a result of the adoption of agenda item 2016-17-CA by the Capital Adequacy (E) Task Force at the Spring National Meeting, a tiered factor approach will be applied to stop loss premiums. A footnote was added to page XR014, Line (22) to apply a factor of 0.350 to the first $25,000,000 in stop loss premium and a factor of 0.250 would be applied to premium in excess of $25,000,000.

Unaffiliated Common Stock Money Market Mutual Funds

As a result of the adoption of agenda item 2017-06-CA, by the Capital Adequacy (E) Task Force on its June 28 conference call, the annual statement reference was modified to Schedule E, Part 2, Column 7, Line 8699999 and the factor was modified to 0% on Line (17) on page XR009. The purpose of the modification was to avoid the double counting of MMMFs in both cash equivalents and common stock. The instructions were also revised to reflect the change.

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Editorial Changes

1. On page XR002, the column name was updated in Column 4 to reflect the changes to page XR025, page PR032 and page LR031 for Operational Risk. The column name was changed to "Affiliate's RBC After Covariance Before Operational Risk" and the line number for life was changed to Line (67) + (70) and the line number for P&C was changed to (73).
2. On page XR022, the references to P&C Supp. Sch. F, Pt1, C5, L0899999 and P&C Supp. Sch. F, Pt1, C5, L0999999 were removed from the Reference column for Line (2), Line (3), Line (6) and Line (7) as a result of Proposal 2017-01BWG, adopted by the Blanks (E) Working Group on its June 14 conference call.
3. The column reference in the instructions for Line (18) on page XR023 was corrected from "Column (2)" to "Column (3)."
4. The annual statement reference was updated from Note 5I to Note 5M on Line (23) and (24) on page XR007 as a result of proposal 2017-13BWG (MOD), adopted by the Blanks (E) Working Group on its June 14 conference call.
5. The annual statement reference was updated to Schedule E, Part 2, Column 7, Line 8699999 on Line (17) on page XR009.

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2017 NAIC Health

Risk-Based Capital Report

Including

Forecasting and Instructions for Companies

as of December 31, 2017

Confidential
when Completed

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NAIC Health Risk-Based Capital Report

INTRODUCTION

Risk-based capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. It provides an elastic means of setting the capital requirement in which the degree of risk taken by the insurer is the primary determinant. The five major categories of risks involved are:

Asset Risk – Affiliates	H–0	This is the risk of assets' default for certain affiliated investments.
Asset Risk – Other	H–1	This is the risk of assets' default of principal and interest or fluctuation in market value.
Underwriting Risk	H–2	This is the risk of underestimating liabilities from business already written or inadequately pricing business to be written in the coming year.
Credit Risk	H–3	This is the risk of recovering receivable amounts from creditors.
Business Risk	H–4	This is the risk of general business.

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 can 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 rehabilitation or liquidation.

PURPOSE OF THIS REPORT

This report presents the NAIC Health Risk-Based Capital formula in an instructional format that should be helpful to anyone responsible for submitting data. This formula is an extremely important tool for regulators. Determining accurate and timely data is an 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 compiling and entering the information be senior company officials with a good understanding of the financial aspects of health business. It is also recommended that companies seek the assistance of their independent accountants and/or actuaries when preparing this 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.

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WHAT'S IN THE REPORT

Certain terms relating to risk-based capital used in this report are defined in the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315).

Generally, each narrative page discusses a different segment of each risk classification (i.e., there is a narrative for Bonds, Mortgages, Preferred and Common Stocks, etc. within the Asset Risk section). The formula is presented in worksheet form following the narrative section.

Most narrative pages have a brief background summary of the development of the factors called the "Basis of the Factors." Development of certain factors require sophisticated modeling techniques but the basic concepts are not complicated.

Many of the sections have a narrative page on "Specific Instructions for Application of the Formula." This section should serve as a guideline for those who assemble the data or analyze the results. It includes definitions and explanations for specific items that should be calculated, clarification on structural intent 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 the current year's total Administrative Expenses on the income statement will read "Page 4, Col 2, Line 21." Annual statement references will begin with a page number only for Pages 2, 3, 4 and 7. Otherwise, the reference will be a schedule letter (e.g., Schedule D or Sch D) or a name of an exhibit or schedule (e.g., Underwriting and Investment Exhibit or UI).

Risk-based capital references in this report will use parentheses around the line and column number. For example, a reference to XR007 – Fixed Income Assets – Bonds, Column 2, Line 9 in this report will read, "Bonds, Col (2), Line (9)."

Negative values can sometimes appear in the value column or RBC Subtotal column of this report. These negative values are retained to facilitate crosschecking of amounts reported in the annual statement against amounts reported in the RBC filing. However, when a negative number appears in the value column, that value will be converted to zero before determining the RBC Requirement. For example, a negative $10,000 for cash [XR007, Col (1), Line (10)] will produce a zero ($0 times 0.003) in Column (2), RBC Requirement, rather than a negative $30 (-$10,000 times 0.003).

MANAGEMENT'S DISCUSSION AND ANALYSIS

Each company has the opportunity to prepare a written analysis of their company's risk-based capital results. This analysis is not a requirement. A company may explain special situations as it deems necessary. Companies should also give explanations where line items do not reconcile with amounts 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 (H0, H1, H2, H3, H4) and the Total Adjusted Capital Amount should not be overwritten. This written analysis should not be construed as the "RBC Plan" required in the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315).

APPLICABILITY OF NAIC HEALTH RBC REPORT

The NAIC Health RBC Report has been developed for companies who file the NAIC Health annual statement "orange blank."

CHANGES TO THE FORMULA

Changes to the formula may be made 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. **The electronic submission is due March 1**. 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 Crystal Brown at 816-783-8146 or *cbrown@naic.org* for RBC formula questions. The NAIC Financial Reporting Questions Help Line can also be contacted at 816-783-8400 for formula and reporting questions.

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AFFILIATED STOCKS
XR002–XR004

This part of the formula only needs to be completed if the reporting entity has ownership in any affiliates within their holding company group. The risk-based capital for insurers and health entities is calculated on a "see through" basis (multiplied by the percent of ownership). This requires "looking through" all holding and subsidiary companies to the lowest level of ownership for each affiliated stock investment. The advantage of this approach is that where there is a choice of whether to have ownership of an asset in either the parent or the subsidiary, RBC results are unlikely to affect that decision.

There are 10 categories of subsidiary and affiliated investments that are subject to a RBC requirement for common stock and preferred stock. Those ten categories are:

1. Directly Owned Insurer Subject To RBC
2. Indirectly Owned Insurer Subject To RBC
3. Directly Owned Health Entity Subject To RBC
4. Indirectly Owned Health Entity Subject To RBC
5. Investment Affiliates
6. Holding Company Value in Excess of Indirectly Owned Subsidiaries
7. Directly Owned Alien Insurance Subsidiaries
8. Indirectly Owned Alien Insurance Subsidiaries
9. Investments in Upstream Affiliates (Parents)
10. Other Affiliated Investments

Codes (1 through 10) will appear in Column (2) of the Affiliated Companies Risk page. 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. 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 RBC report will display the number of subsidiaries and affiliates. These numbers should be reviewed to ensure that all subsidiaries and affiliates are appropriately reported.

Line 11 – Fair Value Excess Affiliate Common Stock equals the total of type codes 1 through 4 of the Affiliated Companies Risk – Details Page. The program will automatically calculate this figure.

Affiliates that are Subject to RBC

The risk-based capital requirement for the reporting company for those subsidiaries that are subject to a risk-based capital requirement is based on the Total Risk-Based Capital After Covariance of the subsidiary, prorated for the percent of ownership of that subsidiary. **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 (73)); 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 (70)).

The risk-based capital for those subsidiaries must be calculated prior to completing this risk-based capital. The following rules apply except when the affiliate's common stock is publicly traded and the reporting company carries the affiliate at fair value, after any "haircut." If the parent owns 100 percent of a downstream affiliate health entity, then the parent's RBC requirement for that asset is equal to the lesser of 100 percent of the health entity's RBC after covariance or the book/adjusted carrying

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value of the affiliate on the parent's statement. If a parent owns 50 percent of a downstream life insurance company, then the parent's RBC requirement for that asset is the lesser of half of the RBC after covariance of its life affiliate or the book/adjusted carrying value of the life affiliate on the parent's statement.

If the affiliate's common stock is publicly traded and the reporting company carries the affiliate at fair value, after any "haircut," there are generally two components to the reporting company's RBC generated by the affiliate. The prorated portion is the percentage of ownership of total common and preferred stock. The smaller of the prorated portion of the affiliate's own statutory surplus or the prorated portion of its RBC after covariance is added to the H-0 component of the reporting company. In the normal case, the fair value of the affiliate exceeds the prorated portion of the larger of its statutory surplus and its RBC after covariance. In this case, the addition to the H-1 component is the larger of a) 22.5 percent of the affiliate's fair value in excess of the prorated portion of the affiliate's statutory surplus or b) the prorated portion of the affiliate's RBC after covariance in excess of the prorated portion of its statutory surplus. If the affiliate's fair value is less than the prorated portion of its RBC after covariance, but greater than the prorated portion of its statutory surplus, 100 percent of the fair value in excess of the prorated portion of the affiliate's statutory surplus is added to the reporting company's H-1 component. If the affiliate's fair value is less than the prorated portion of the affiliates' s statutory surplus, there is no addition to the H-1 component.

The subsidiaries affected by this rule are:

1. Directly Owned Insurers Subject To RBC
2. Indirectly Owned Insurers Subject To RBC
3. Directly Owned Health Entity Subject To RBC
4. Indirectly Owned Health Entity Subject To RBC

Directly owned insurance and health entity subsidiaries are subsidiaries in which the parent owns the stock of the affiliate. Indirectly owned insurance subsidiaries and indirectly owned health entities are those where the parent owns stock in a holding company, and the holding company in turn owns the stock of the insurance subsidiary or health entity.

Directly Owned Insurance Subsidiaries

Report information regarding any top-layer directly owned U.S. Property and Casualty insurance subsidiaries or U.S. Life insurance subsidiaries in the schedule. For each subsidiary, report its name, NAIC company code, affiliates Total Risk-Based Capital after Covariance, value of the common stock from Schedule D, Part 6, Section 1, Line 1199999 or Line 1299999 in Columns (1) through (7). If no value is reported in the Total Value of Affiliate's Outstanding Common Stock column (Column (7)), the program will assume 100 percent ownership. If the reporting company does not own any of the affiliate's common stock but does own preferred stock, the Total Value of Affiliate's Outstanding Common Stock in Column (7) must be reported so the program can calculate the percent of ownership. Subsidiaries reported in this section will be assigned an affiliate code of "1" for directly owned insurers.

The book/adjusted carrying value of any preferred stock is reported in Column (9) and should equal the amount reported in Schedule D, Part 6, Section 1, Line 0299999 or 0399999. The total outstanding value of the affiliate's preferred stock is reported in Column (10). The percentage of ownership will be automatically calculated in Column (11). For companies owning both preferred and common stock in the same subsidiary, the percent of ownership is calculated by summing the book/adjusted carrying values of the owned preferred and common stock and dividing that amount by the sum of all outstanding preferred and common stock.

The risk-based capital reported for each insurance subsidiary should be obtained by using a separate copy of the Property and Casualty risk-based capital program, Health risk-based capital program or the Life risk-based capital program. Title insurers, monoline financial guaranty insurers and monoline mortgage guaranty insurers are not subject to risk-based capital. Additionally, some insurers are granted exemptions from filing risk-based capital. These affiliates and other similar affiliates should be reported as Other Affiliated Investments.

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Indirectly Owned Insurance Affiliates

The reporting company's book/adjusted carrying value of the holding company should be allocated between any top-layer, indirectly owned insurance affiliates and the Holding Company Value in Excess of Indirectly Owned Insurance Affiliates. The book/adjusted carrying value of the holding company should be first allocated based on the values shown on the holding company's balance sheet. An example of the calculation is presented in the following example. The example shows a hypothetical holding company, Holder, Inc., that is 100 percent owned by Big HMO and illustrates the allocation of Holder's book/adjusted carrying value among these categories.

Balance Sheet
Holder, Inc.
12/31/XX

ABC Life	$4,000,000	Long-Term Debt	$14,000,000
XYZ HMO	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 Liabilities and Equity	$24,000,000

Since ABC Life Insurance Company makes up one-sixth ($4,000,000 divided by $24,000,000) of the total assets for Holder, Inc., then this indirectly owned U.S. affiliate represents one-sixth of the book/adjusted carrying value of Holder, Inc. on the statement of Big HMO Company. Similarly, the indirectly owned U.S. affiliate XYZ HMO represents one-twelfth of the book/adjusted carrying value ($2,000,000 divided by $24,000,000) of Holder on Big HMO's annual statement. Non-U.S. Casualty, which is an alien insurance affiliate, represents one-fourth of the carrying value ($6,000,000 divided by $24,000,000) of Holder on Big HMO's annual statement. One-half of the book/adjusted carrying value of Holder, Inc. ($12,000,000 divided by $24,000,000) represents the Holding Company Value in Excess of Indirectly Owned Insurance Affiliates. If Big HMO carries Holder, Inc. on its annual statement at $30,000,000 (assume that this is the current market value of shares in Holder, which was a publicly traded corporation of which Big has just acquired 100 percent ownership), then Big HMO will allocate one-sixth of the $30,000,000 to ABC Life, one-twelfth of the $30,000,000 to XYZ HMO, one-fourth of the $30,000,000 to Non-U.S. Casualty, and one-half 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 ABC's Total RBC after Covariance, adjusted for percent of ownership if Holder owns less than 100 percent. If Holder owns 50 percent of ABC Life, then only 50 percent of the RBC after Covariance would be entered in Column (4). However, in our example, Holder owns all outstanding shares of ABC Life, XYZ HMO and Non-U.S. Casualty. The RBC charge for the indirect ownership of XYZ HMO and Non-U.S. Casualty would be computed in the same manner.

If Big only acquired 50 percent of the shares of Holder, then the total outstanding common stock value in Column (7) would be adjusted to reflect Big HMO'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 market value, then the allocations follow as described in (A). If the carrying value of Holder is based on its market value, then the allocations and any additional RBC due to the use of market value are described in (B).

(A) The book/adjusted carrying value (not based on market value) on Big HMO's annual statement is $15,000,000 which is allocated as $2,500,000 to ABC Life (one-sixth of $15,000,000), $1,250,000 to XYZ HMO (one-twelfth of $15,000,000), $3,750,000 to Non-U.S. Casualty (one-fourth 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 Affiliates. The total outstanding value for the common stock of ABC Life, Column (7), would be $5,000,000 ($2,500,000 divided by 0.50) and the total outstanding value of common stock for XYZ HMO would

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be $2,500,000 ($1,250,000 divided by .50). The total outstanding value of common stock for Non-U.S. Casualty would be $7,500,000 ($3,750,000 divided by 0.50). The total outstanding value of common stock for Holder would be $15,000,000 ($7,500,000 divided by 0.50).

(B) In this example the book/adjusted carrying value (based on market value) on Big HMO'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 insurers and health entities subject to RBC. For example, the amount of Holder applicable to ABC Life, $3,000,000 (1/6 of $18,000,000) will also have subtracted from it, its statutory surplus** (prorated 50 percent for its partial ownership) and if a positive amount results, then that amount will receive an RBC charge of 22.5 percent and reported as a component of such stock in the formula. The same will apply to XYZ HMO.

The allocation of the RBC of the indirectly owned affiliates will be automatically adjusted to reflect the fact that Big HMO only owns 50 percent of the affiliates because Column (11) will divide Column (5) by Column (7) before allocating the RBC. Therefore, only half of the RBC after covariance for these indirectly owned affiliates would accrue to Big HMO.

The information for all top-layer, indirectly owned insurance affiliates is reported in the appropriate columns within the Affiliated Companies Risk page. For each affiliate report its name, NAIC company code and the prorated share of risk-based capital along with all other information required in Columns (1) through (10). Subsidiaries reported in this section will be assigned an affiliate code of "3" for indirectly owned insurers. 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 (12) and (13).

* This step also applies to directly owned insurers and health entities subject to RBC.
** The amount of total statutory surplus appearing on its filed annual statement as shown on Page 3, Line 33, Column 3.

Directly Owned Health Entity

Report information regarding any top-layer directly owned health entity subsidiaries in this schedule. For each subsidiary, report its name, NAIC company code, affiliates Total Risk-Based Capital after covariance, value of the common stock included in Schedule D, Part 6, Section 1, Line 1399999 in Columns (1) through (7). If no value is reported in the Total Value of Affiliate's Common Stock Column (Column (7)), the program will assume 100 percent ownership. If the reporting company does not own any of the affiliate's common stock but does own preferred stock, the Total Value of Affiliate's Common Stock in Column (7) must be reported so the program can calculate the percent of ownership. Subsidiaries reported in this section will be assigned an affiliate code of "3" for directly owned health entities.

The book/adjusted carrying value of any preferred stock is reported in Column (9) and should equal the amount reported in Schedule D, Part 6, Section 1, Line 0499999. The total outstanding value of the affiliate's preferred stock is reported in Column (10). The percentage of ownership will be automatically calculated in Column (11). For companies owning both preferred and common stock in the same subsidiary, the percent of ownership is calculated by summing the book/adjusted carrying values of the owned preferred and common stock and dividing that amount by the sum of all outstanding preferred and common stock.

The risk-based capital to be reported for each insurance subsidiary should be obtained by using a separate copy of the health risk-based capital program for each subsidiary.

Indirectly Owned Health Entity

Indirectly owned health entity affiliates are treated in a manner similar to indirectly owned insurance affiliates. Note that the health entity affiliate must be subject to risk-based capital and file a risk-based capital 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. Subsidiaries reported in this section will be assigned an affiliate code of "4" for indirectly owned health entity.

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Affiliates that are not Subject to Risk-Based Capital

This category includes the last six categories of affiliated investments:

5. Investment Affiliates
6. Holding Company Value in Excess of Indirectly Owned Subsidiaries
7. Directly Owned Alien Insurance Subsidiaries
8. Indirectly Owned Alien Insurance Subsidiaries
9. Investments in Upstream Affiliates (Parents)
10. Other Affiliated Investments

Insurance affiliates that are not subject to risk-based capital, such as title insurers, monoline financial guaranty insurers, and monoline mortgage guaranty insurers are classified as Other Affiliated Investments.

The risk-based capital charge for these investments is calculated by multiplying a factor times the book/adjusted carrying value of the common and preferred stock of those affiliates. The risk-based capital factor for Alien Insurance Affiliates is 100 percent; the factor for Investment Affiliates; Holding Company Value in Excess of Indirectly Owned Affiliates, Investments in Upstream Affiliates (Parents), and Other Affiliated Investments is 30 percent of the book/adjusted carrying value of the common and preferred stock 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 NAIC's 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 30 percent of the book/adjusted carrying value of the common and preferred stock.

Holding Company Value in Excess of Indirectly Owned Affiliates

The risk-based capital charge for the parent insurer preparing the calculation is a 30 percent charge against the holding company value in excess of the indirectly owned insurance affiliates as calculated in the prior example.

Report information in the appropriate columns of the Affiliated Companies Risk page, omitting those columns that do not apply (Column (3) – NAIC Company Code or Alien ID Number and Column (4) affiliate's risk-based capital).

The total of Indirectly Owned Insurers, Indirectly Owned **H**ealth **E**ntities, Indirectly Owned Alien Insurers, and the amount of Holding Company Value in Excess of Indirectly Owned Insurance Affiliates should equal Schedule D, Part 6, Section 1, Line 0699999 for the reporting of preferred stock and Schedule D, Part 6, Section 1, Line 1599999 for common 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 100 percent. Report information for any non-U.S. insurance affiliate, both Life and Property and Casualty.

For each affiliate, report the name, Alien Insurer Identification Number, the book/adjusted carrying value of common and preferred stock, and the total outstanding value of common and preferred stock. Companies reported in this section will be assigned an affiliate code of "7" for directly owned alien insurers.

Not for Distribution

The total of Alien Insurance Affiliates should equal the amounts reported in Schedule D, Part 6, Section 1, Line 0599999 and Line 1499999.

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 100 percent, and adjusted to reflect the reporting company's ownership on the holding company. Subsidiaries reported in this section will be assigned an affiliate code of "8" for indirectly owned alien insurers.

Investment in Upstream Affiliate (Parent)

The risk-based capital for an investment in an upstream parent is 30 percent of the book/adjusted carrying value of the common and preferred stock regardless of whether that upstream parent is subject to risk-based capital or not. Report the appropriate information from Schedule D, Part 6, Section 1, Lines 0199999 and 1099999 in Columns (1) through (10). The affiliate code for an upstream parent is "9."

Other Affiliated Investments

The risk-based capital for an investment in an Other Affiliated Investment is 30 percent of the book/adjusted carrying value of the common and preferred stock. All insurance affiliates that do not otherwise qualify for another section of this report, such as title insurance companies, or a Life insurance affiliate that has been exempted from the risk-based capital system are to be included in this category. The affiliate code for Other Affiliated Investments is "10." Reported amounts use Schedule D, Part 6, Section 1, Line 0899999 and Line 1799999 as the basis of reporting and additionally include any Life and Property and Casualty insurers not subject to risk-based capital (as discussed earlier).

OFF-BALANCE SHEET AND OTHER ITEMS
XR005

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 percent (or 105 percent for cross currency loans).
    e. Daily mark-to-market of lent securities and obtaining additional collateral needed to maintain a margin of 102 percent 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).

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

Lines (3) through (14) – 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 Lines (12) and (13), include assets pledged as collateral reported in the General Interrogatories Part 1, Lines 25.30 and 25.31 other than assets related to the Federal Reserve's Term Asset Loan Facility (TALF).

Line (16) – Guarantees for Affiliates include loan guarantees or other undertakings for the benefit of an affiliate which results in a material contingent exposure of the company's or any affiliated insurer's assets. The definition of "material" exposure or financial effect is the same as for annual statement disclosure requirements.

Line (17) – 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 of liability from a third party.*

Line (18) – "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 U.S. 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 U.S. Federal income tax return; Lines (19) and (20) should be zero in this case.

Lines (19) and (20) - 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—Income Taxes*, 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 U.S. Federal income tax return or it was included in a consolidated U.S. 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).

OFF-BALANCE SHEET SECURITY LENDING COLLATERAL AND SCHEDULE DL, PART 1 ASSETS
XR006

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/adjusted carrying value, and maturity date.

Not for Distribution

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 page XR007 – Fixed Income Assets

Line (10) through (16) – Preferred Stock – Preferred stock factors described on page XR009 – Equity Assets

Line (17) – Common Stock – Common stock factors described on page XR009 – Equity Assets

Line (18) – Real Estate and Property and Equipment Assets – Real Estate and Property and Equipment Assets factors described on page XR010 – Property & Equipment Assets

Line (19) – Other Invested Assets – Other invested assets factor described on page XR007 – Fixed Income Assets

Line (20) – Mortgage Loans on Real Estate – Mortgage Loans on Real Estate factors described on page XR007 – Fixed Income Assets

Line (21) – Cash, Cash Equivalents and Short-Term Investments – Cash, Cash Equivalents and Short-Term Investments factors described on page XR007 – Fixed Income Assets

FIXED INCOME ASSETS
XR007

The RBC requirement for fixed income assets is largely driven by the default risk on those assets. There are two major subcategories: Bonds and Miscellaneous. Bonds are obligations issued by business units, governmental units, and certain nonprofit units, having a fixed schedule for one or more future payments of money. This definition includes commercial paper, negotiable certificates of deposit, repurchase agreements, and equipment trust certificates. Miscellaneous fixed income assets are other assets with fixed repayments schedules, such as mortgages and collateral loans.

Bonds

The 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 ten-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 designation category and that year's economic environment. When a default takes place, the actual loss considers the expected principal loss by category, the time until the sale actually occurs, and the assumed tax consequences. Only default risk is recognized in the RBC factors because, under statutory accounting, bonds are generally carried at their amortized value on the statutory annual statement, so changes in the market value of the bonds following swings in interest

Not for Distribution

rates do not, as a general rule, affect the capital and surplus of the regulated entities unless the bonds are actually sold. The accounting for reporting entities can be substantially different from other regulated entities, but the RBC formula continues to recognize only default risk.

There is no RBC requirement for bonds guaranteed by the full faith and credit of the United States because there is virtually no default risk associated with these securities.

The factor for NAIC 06 bonds recognizes that the book/adjusted carrying value of these bonds reflects a loss of value upon default by being marked to market.

The book/adjusted carrying value of all bonds and related fixed income investments should be reported in Column (1). The bonds are split into seven different risk classifications. These risk classifications are based on the NAIC designations assigned. For long-term bonds, these classifications are found on Lines 10.1 through 10.6 less the hybrids Lines 7.1 through 7.6 of Schedule D, Part 1A, Section 1 of the annual statement.

Enter the book/adjusted carrying value of the bonds, by NAIC designation category, in Column (1). The RBC requirement will be automatically calculated in Column (2).

Miscellaneous Fixed Income Assets

The factor for cash is 0.3 percent. It is recognized that there is a small risk related to possible insolvency of the bank where cash deposits are held. This 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.

The Short-Term Investments to be included in this section are those short-term investments not reflected elsewhere in the formula. The 0.3 percent 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, Column 7, Line 8399999 less bonds that are contained in Schedule D, Part 1A, Section 1.

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

The book adjusted carrying value of NAIC 01 and 02 Working Capital Finance Investments, Lines (24) and (25), should equal the Notes to Financial Statement, Lines 5**M**(01a) and 5**M**(01b), Column 3 of the annual statement.

Other Long-Term Invested Assets are those that are listed in Schedule BA and are somewhat more speculative and risky than most other investments. Therefore, a 20 percent factor is consistent with other risk-based capital formulas studied by the working group.

Low income housing tax credit investments are reported in 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 (27). 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 (28):

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.

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State Guaranteed LIHTC investments that at a minimum meet the federal requirements for guaranteed LIHTC investments are to be included in Line (29).

State Non-Guaranteed LIHTC investments that at a minimum meet the federal requirements for non-guaranteed LIHTC investments are to be included on Line (30).

All Other LIHTC investments (state and federal LIHTC investments that do not meet the requirements of Lines (27) through (30) would be reported on Line (31).

REPLICATION (SYNTHETIC ASSET) TRANSACTIONS AND MANDATORY CONVERTIBLE SECURITIES

XR008

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, Section 1.

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. 26—Bonds*. This worksheet adjusts the RBC requirement upward if the security that results from the conversion is more risky than the original security.

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 the RSAT number, next by type (replicated assets first, then cash instruments, then mandatory convertible securities, and the security that results from the conversion) 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 and all mandatory convertible securities and all securities that will result from a mandatory conversion.

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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 of the asset. For replications (synthetic assets) this is contained in Columns 3 or 14 of Schedule DB, Part C, Section 1.

Column (6): Give the book/adjusted carrying value of the asset. For replications (synthetic assets) this is contained in Columns 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 asset designation of the asset times the book/adjusted carrying value contained in Column (6). For cash instrument components that qualify for an 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 asset 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 book/adjusted carrying value contained in Column 6, times
(c) –1.

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

EQUITY ASSETS
XR009

Unaffiliated Preferred Stocks

Experience data to develop preferred stock factors is not readily available; however, it is believed that preferred stocks are somewhat more likely to default than bonds. The loss on default would be somewhat higher than that experienced on bonds; however, formula factors are equal to bond factors.

The RBC requirements for unaffiliated preferred stocks and hybrids are based on the NAIC designation. Column (1) amounts are from Schedule D, Part 2, Section 1 not including affiliated preferred stock. The preferred stocks and hybrids must be broken out by asset designation (NAIC 01 through NAIC 06) and these individual groups are to be entered in the appropriate lines. The total amount of unaffiliated preferred stock and hybrids reported should equal annual statement Page 2, Column 3, Line 2.1, less any affiliated preferred stock in Schedule D Summary by Country, Column 1, Line 18. The total amount of hybrid securities reported should equal annual statement Schedule D, Part 1A, Section 1, Column 7, Line 7.7.

Unaffiliated Common Stock

Non-government money market mutual funds are more like cash than common stock, therefore it is appropriate to use the same factors as for cash. Federal Home Loan Bank Stock has characteristics more like a fixed income instrument rather than common stock. A 2.3 percent factor was chosen. The factor for other unaffiliated common stock is based on studies which indicate that a 10 percent to 12 percent factor is needed to provide capital to cover approximately 95 percent of the greatest losses in common stock over a one-year future period. The higher factor of 15 percent contained in the formula reflects the increased risk when investing a period in excess of one year. This factor assumes capital losses are unrealized and not subject to favorable tax treatment at the time of loss in market value.

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ASSET RISK – PROPERTY & EQUIPMENT
XR010

There are five subcategories of "Property & Equipment Assets": (1) Properties Occupied by the Company; (2) Properties Held for the Production of Income; (3) Properties Held for Sale; (4) Furniture and Equipment; and (5) EDP Equipment and Software.

Encumbrances have been included in the real estate bases since the value of the property subject to loss would include encumbrances.

Classify Furniture and Equipment into: (1) the portion used to deliver health care that is subject to statutory accounting depreciation limits; and (2) all other. Category (1) should include only that furniture and equipment which has had its depreciation period limited to no more than three years pursuant to *SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities*. Category (2) should include all other furniture and equipment, or that furniture and equipment whose depreciation periods are not limited by *SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities*, i.e., the depreciation period is based on useful life. If the filing entity's state of domicile has a permitted practice that preempts *SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities*, all furniture and equipment should be classified in Category (2).

ASSET CONCENTRATION
XR011

The purpose of the asset concentration calculation is to reflect the additional risk of high concentrations of certain types of assets in single exposures, termed "issuers." An issuer is a single entity, such as IBM or the Ford Motor Company. When the reporting entity has a large portion of its asset portfolio concentrated in only a few issuers, there is a heightened risk of insolvency if one of those issuers should default. An issuer may be represented in the reporting entity's investment portfolio by a single security designation, such as a large block of NAIC 02 bonds, or a combination of various securities, such as common stocks, preferred stocks, and bonds. The additional RBC for asset concentration is applied to the ten largest issuers.

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 ten 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 and preferred stock; affiliated common stock; affiliated preferred stock; affiliated bonds; property and equipment; U.S. government guaranteed bonds; NAIC 01 bonds, preferred stock and hybrids; any other asset categories with risk-based capital factors less than 1 percent**,** and investment companies (mutual funds) and common trust funds that are diversified within the meaning of the federal 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 entity is responsible for maintaining the appropriate documentation as evidence that such is diversified within the meaning of the federal Investment Company Act and providing this information upon request of the Commissioner, Director or Superintendent of the Department of Insurance. The reporting entity 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.

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The assets that **ARE INCLUDED** in the calculation when determining the 10 largest issuers are as follows:

NAIC 02 Unaffiliated Bonds
NAIC 03 Unaffiliated Bonds
NAIC 04 Unaffiliated Bonds
NAIC 05 Unaffiliated Bonds
Collateral Loans
Mortgage Loans
NAIC 02 Unaffiliated Preferred Stock
NAIC 03 Unaffiliated Preferred Stock
NAIC 04 Unaffiliated Preferred Stock
NAIC 05 Unaffiliated Preferred Stock
NAIC 02 Hybrids
NAIC 03 Hybrids
NAIC 04 Hybrids
NAIC 05 Hybrids
Other Long-Term Assets
NAIC 02 Working Capital Finance Investments
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 Common Stock

The concentration factor basically doubles the risk-based capital factor (up to a maximum of 30 percent) for assets held in the 10 largest issuers. 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.

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 Column (2), Lines (1) through (22). Aggregate all similar asset types before entering the amount in Column (2). To determine the 10 largest issuers, first pool all of the assets subject to the concentration factor. From this pool, aggregate the various securities by issuer. The aggregate book/adjusted carrying values for the assets are computed, and the 10 largest are subject to the concentration factor. For example, an organization might own $10,000,000 in NAIC 02 bonds of IBM plus $5,000,000 of common stock. The total investment in that issuer is $15,000,000. If that is the largest issuer, then the identifier ("IBM Corporation") would be entered in the space allowed for the first Issuer Name, and the $10,000,000 would be entered under the book/adjusted carrying value column for Line (1) (NAIC 02 unaffiliated bonds) and the $5,000,000 would be entered on Line (22) (unaffiliated common stock).

Replicated assets other than synthetically created indices should be included in the asset concentration calculation in the same manner as other assets.

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UNDERWRITING RISK - L(1) THROUGH L(18)

XR012

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

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

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

Claims Experience Fluctuation

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

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

or

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

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

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L(1) through L(18)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; and (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

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

Column (2) - Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

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

Column (4) - Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See Appendix 2 for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR014. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

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

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

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

Line (1) Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Beneficiary premium (supplemental benefit portion) is reported as separate premium in Line (22.1) of XR014.

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

Line (2) Title XVIII Medicare. This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

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

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

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

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

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

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

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

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

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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 & Hospital	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
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

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

Line (12) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

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

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

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

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

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.

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

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

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Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

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

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

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

Line (15) Alternate Risk Charge**.** This is twice the amount in Line (14) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (14), subject to a maximum of $1,500,000 for Column (1), $50,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.

Line (16) Alternate Risk Adjustment**.** This line shows the largest value in Line (15) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (17) Net Alternate Risk Charge**.** This is the amount in Line (15), less the amount in the previous column of Line (16), but not less than zero. Column (6) is excluded from this calculation.

Line (18) Net Underwriting Risk RBC**.** This is the maximum of Line (13) and Line (17) for each of columns (1) through (5). This is the amount in Line (11), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

UNDERWRITING RISK
XR012-A
(FOR INFORMATIONAL PURPOSES ONLY)

Underwriting risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page XR012 generates the RBC requirement for the risk of fluctuations in underwriting experience. The Underwriting Risk page XR012-A will be for informational purposes only for 2017 reporting for health entities.

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This page will break out premiums, claims and the loss ratio by individual, small group and large group. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

The purpose of this page is to break out premiums, claims and the loss ratio for coverage subject to the federal Affordable Care Act (ACA) risks on a more granular level (individual, small group and large group) to allow regulators to analyze the impact of the ACA on a health insurance entity. By breaking out the premiums, claims and loss ratio into individual, small group and large group, regulators will be able to better identify if the health entity has had a change in their writings through the individual or group markets and analyze a company's risk pool by the claims reported. This information will provide regulators with the data needed to analyze and identify if separate risk charges should apply to individual, small group and large group plans in the future. This data will again only be for informational purposes for 2017 reporting.

The reporting of this page will follow the reporting of page XR012–Underwriting Risk and will be on the basis of the health annual financial statement filing. A company may not have the values in Lines (4) and (15) separated into the three market segments. An allocation of the value in Line (4) based on earned premium reported by market segment in the company's preparation of the Supplemental Health Care Exhibit may be used as company records in completing Lines (1) through (3). Similarly, an allocation of the value in Line (15) based on incurred claims reported by market segment in the company's preparation of the Supplemental Health Care Exhibit may be used. If the company is unable to complete the schedule, an explanation should be provided in the footnote as to why the company is unable to provide this information.

L(1) through L(33)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; and (5) Other Health; and (6) Other Non-Health. These lines of business are based on the health annual financial statement reporting and do not coincide with the lines of business reported in the Supplemental Health Care Exhibit. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

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

Column (2) - Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

Column (3) - Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, that is not related to the medical policy through deductibles or out-of-pocket limits. Column (3) should be completed for Lines (1) through (3), (9) through (11) and (14) and (18) through (20) if the earned premium in Column (3), Line (4) is five percent or more than the earned premium reported in Column (1), Line (4).

Column (4) - Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See Appendix 2 for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess

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of the standard benefit design) are addressed separately on page XR014. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

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

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

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

Line (1) Individual Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by an individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include Federal Employees Health Benefit Program (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns will be based on company records for coverage for the Individual market as defined by the ACA.

Line (2) Small Group Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by or for a small group plan to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include Federal Employees Health Benefit Program (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns will be based on company records for coverage in the Small Group market as defined by the ACA.

Line (3) Large Group Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a large group to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts or administrative services contracts (ASC); or any non-underwritten business. Nor does it include Federal Employees Health Benefit Program (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns will be based on company records for coverage in the Large Group market as defined by the ACA.

Line (4) Total Premium**.** This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include the Federal Employees Health Benefit Program (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. The amount reported in Line (4) for the Comprehensive Medical and Dental and Vision columns should be equal to the sum of Lines (1) through (3). For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. It does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues (E) Working Group INT. No. 05-05 – Beneficiary Premium (supplemental benefit portion) is reported as separate premium in Line (22.1) on page XR014.

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.

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Line (5) Title XVIII Medicare**.** This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

Line (6) Title XIX Medicaid. This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Medicare Part D coverage of low-income enrollees is not included in this line.

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

Line (8) Underwriting Risk Revenue. The sum of Lines (4) through (7).

Line (9) Individual Net Incurred Claims. Claims incurred for individual plans (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or Federal Employees Health Benefit Program (FEHBP) and TRICARE claims. These amounts reported in the individual columns will be based on company records for coverage for the Individual market as defined by the ACA.

Line (10) Small Group Net Incurred Claims. Claims incurred for small group plans (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or Federal Employees Health Benefit Program (FEHBP) and TRICARE claims. These amounts reported in the individual columns will be based on company records for coverage in the Small Group market as defined by the ACA.

Line (11) Large Group Net Incurred Claims. Claims incurred for large group plans (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or Federal Employees Health Benefit Program (FEHBP) and TRICARE claims. These amounts reported in the individual columns will be based on company records for coverage in the Large Group market as defined by the ACA.

Line (12) Title XVIII-Medicare Net Incurred Claims. Claims incurred for Medicare Risk Coverage during the reporting year (net of reinsurance) during the reporting year.

Line (13) Title XIX-Medicaid Net Incurred Claims. Claims incurred for Medicaid Risk Coverage during the reporting year (net of reinsurance) during the reporting year.

Line (14) Other Health Net Incurred Claims. Claims incurred for Other Health Coverage during the reporting year (net of reinsurance) during the reporting year. The amounts reported will be based on company records.

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Line (15) Total Net Incurred Claims. Total Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or Federal Employees Health Benefit Program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement. Line (15) should also equal the sum of Lines (9) through (14).

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 claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS.

Line (16) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (17) Underwriting Risk Incurred Claims. Line (15) minus Line (16).

Line (18) Individual Underwriting Risk Claims Ratio. Line (9) / Line (1). If either Line (1) or Line (9) is zero or negative, Line (18) is zero.

Line (19) Small Group Underwriting Risk Claims Ratio. Line (10) / Line (2). If either Line (2) or Line (10) is zero or negative, Line (19) is zero.

Line (20) Large Group Underwriting Risk Claims Ratio. Line (11) / Line (3). If either Line (11) or Line (3) is zero or negative, Line (20) is zero.

Line (21) Title XVIII-Medicare Underwriting Risk Claims Ratio. Line (12) / Line (5). If either Line (12) or Line (5) is zero or negative, Line (21) is zero.

Line (22) Title XIX-Medicaid Underwriting Risk Claims Ratio. Line (13) / Line (6). If either Line (13) or Line (6) is zero or negative, Line (22) is zero.

Line (23) Other Health Underwriting Risk Claims Ratio. Line (14) / Line (7). If either Line (14) or Line (7) is zero or negative, Line (23) is zero.

Line (24) Underwriting Risk Claims Ratio. Line (17) / Line (8). If either Line (17) or Line (8) is zero or negative, Line (24) is zero.

Line (25) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (8), Underwriting Risk Revenue.

	$0 – $3 Million	$3 – $25 Million	Over $25 Million
Comprehensive Medical & Hospital	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
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

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Line (26) Base Underwriting Risk RBC. Line (8) x Line (24) x Line (25).

Line (27) Managed Care Discount Factor. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

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

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

Line (28) RBC After Managed Care Discount. Line (26) x Line (27).

Line (29) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

* Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than $750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and $750,000.
* Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to $750,000 less retention).

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

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention)	$100,000
Reinsurance Coverage	90% of $500,000 in excess of $100,000
Maximum reinsured coverage	$600,000 ($100,000 + $500,000)

Maximum Ret. Risk =	$100,000	deductible
	+ $150,000	($750,000 – $600,000)
	+ $ 50,000	(10% of ($600,000 – $100,000) coverage layer)
	= $300,000	

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EXAMPLE 2 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention)	$75,000
Reinsurance Coverage	90% of $1,000,000 in excess of $75,000
Maximum reinsured coverage	$1,075,000 ($75,000 + $1,000,000)

Maximum Ret. Risk =	$ 75,000	deductible
	+ 0	($750,000 – $1,075,000)
	+ $ 67,500	(10% of ($750,000 – $75,000)) coverage layer)
	= $142,500	

Line (30) Alternate Risk Charge. This is twice the amount in Line (29) for Columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (29), subject to a maximum of $1,500,000 for Column (1), $500,000 for Columns (2), (3) and (5) and $150,000 for Column (4). Column (6) is excluded from this calculation.
Line (31) Alternate Risk Adjustment. This line shows the largest value in Line (30) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (32) Net Alternate Risk Charge. This is the amount in Line (30), less the amount in the previous column of Line (31), but not less than zero. Column (6) is excluded from this calculation.

Line (33) Net Underwriting Risk RBC. This is the maximum of Line (28) and Line (32) for each of Columns (1) through (5). This is the amount in Line (26), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

Footnote 1a: If your company is unable to complete this schedule, please provide an explanation. If the company is unable to provide a breakout of the company's premiums, claims and loss ratio by individual, small group or large group plan type as indicated in these instructions, an explanation should be provided as to why the company cannot provide this information.

Footnote 1b: If your company allocated Lines (4) and (15) into Lines (1) through (3) and (9) through (14) describe the basis of the allocation. Describe the basis the company used to allocate the values in Lines (4) and (15) into the three market segment lines. For example: The company used its work papers for completing the Supplemental Health Care Exhibit to allocate the earned premium in Line (4) and incurred claims in Line (15) by the three market segments defined in the ACA.

Footnote 1c: Does the allocation basis reflect estimated impacts of the ACA reinsurance, risk adjustments and risk corridor? The footnote recognizes the potential that estimates of the receivables and payables with respect to the ACA programs identified as reinsurance, risk adjustment and risk corridors may not be possible or may be misleading in this informational page. If the company is concerned that the values may be misleading, it may wish to highlight this concern in the footnote.

Footnote 2: Please explain how your company defines "small group" for the purposes of this form and what the source of your company's data is; i.e., does your company use the federal definition, the definition of each state the company is doing business in, or any other methodology for defining "small group."

Footnote 3: List the percentage of individual premiums earned that are written inside of the exchange (a)_____ and the percentage of individual premiums earned that are written outside of the exchange (b)_____. List the percentage of individual incurred claims on policies written inside of the exchange (c)_____ and the percentage of individual incurred claims on policies written outside of the exchange (d)_____. The company should provide the percentage of individual premiums earned inside and outside of the exchange reported in Line (1), Column (1) in Footnote 3(a) and 3(b), and the percentage of individual incurred claims on policies written inside and outside of the exchange in Line (9), Column (1) in Footnote 3(c) and 3(d), the sum of Footnote 3(a) and 3(b) should equal 100% and the sum of Footnote 3(c) and 3(d) should equal 100%. The footnote should not be left blank.

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Footnote 4: If your company had to allocate the accruals for premiums and claims inside and outside of the exchanges included in Footnote 3, explain the methodology that your company used to allocate these accruals. Provide an explanation of the methodology used to allocate the accruals for premiums and claims.

OTHER UNDERWRITING RISK – L(19) THROUGH L(42)

XR014–XR016

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

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the Federal Employees Health Benefit Program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by two percent to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to **the** Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive 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 premium in excess of $25,000,000.**

Line (22.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in Appendix 2) for the **incurred claims associated with the** beneficiaries for these supplemental drug benefits.

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

Lines (30) through (38) Long Term Care. Long-Term Care Insurance (LTCI) Premiums are used to determine both a rate risk and the morbidity risk. The rate risk relates to all Noncancellable LTCI premiums. The morbidity risk is partially applied directly to premium with a higher factor (10 percent) applied to amounts up to $50,000,000 and a lower factor (3 percent) applied to premiums in excess of $50,000,000. In addition, the earned premiums and incurred claims for the last two years are used to determine an average loss ratio (incurred claims divided by earned premiums). This average loss ratio times the current year's premium is called Adjusted LTCI Claims for RBC. A higher factor (25 percent) is applied to claims up to $35,000,000 and a lower factor (8 percent) is applied to claims above $35,000,000. In certain situations where loss ratios cannot be used because one of the values is zero or negative, the current year's incurred claims are used. In a situation where the current year's premium is not positive, higher factors are applied to current year's incurred claims to reflect the lack of a premium-based RBC. The RBC for LTCI is the sum of these three calculations.

Not for Distribution

Line (39) Limited Benefit Plans. There is a factor for certain types of Limited Benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5 percent) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

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

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

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

Line (41) Other Accident. There is a factor for Other Accident coverage that provides for any accident-based contingency other than those contained in Line 40. For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

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

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

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

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

As such, the company must exclude all amounts relating to FEHBP, TRICARE or stand-alone Medicare Part D Coverage in determining the amount of reserves to be reported here.

Not for Distribution

UNDERWRITING RISK – MANAGED CARE CREDIT
XR017

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

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

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

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

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

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

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

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

Not for Distribution

This amount should equal Exhibit 7, Part 1, Column 1, Line 5 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

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

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

This amount should equal Exhibit 7, Part 1, Column 1, Line 6 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

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 – 2017 Reporting Year

2016 withhold / bonus payments	750,000
2016 withholds / bonuses available	1,000,000
A. MCC Factor Multiplier	75% – Eligible for credit
2016 withholds / bonuses available	1,000,000
2016 claims subject to withhold - gross*	5,000,000
B. Average Withhold Rate	20%
Category 2 Managed Care Credit Factor (A x B)	15%

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

*** These are amounts due before deducting withhold or paying bonuses.**
**** These are actual payments made after deducting withhold or paying bonuses.**

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses, but otherwise had no managed care arrangements. This amount should equal Exhibit 7, Part 1, Column 1, Line 7 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

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

Not for Distribution

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

Enter the paid claims for the current year where payments to providers were subject to withholds and bonuses AND where the payments were made according to one of the contractual arrangements listed for Category 1. This amount should equal Exhibit 7, Part 1, Column 1, Line 8 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

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

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

Enter the amount of claim payments paid DIRECTLY to licensed providers on a capitated basis. This amount should equal Exhibit 7, Part 1, Column 1, Line 1 + Line 3 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

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

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

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

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

- All capitation or percent of premium payments to intermediaries that in turn pay licensed providers. (Subject to a 5 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.

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

Not for Distribution

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

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

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

This amount should equal Exhibit 7, Part 1, Column 1, Line 9 + Line 10 of the annual statement excluding Stand-Alone Medicare Part D business reported in Lines (12) and (13).

Line (9) – Sub-Total Paid Claims. The total of paid claims for Comprehensive Medical, Medicare Supplement and Dental [should equal the total claims paid for the year as reported in Exhibit 7, Part 1, Column 1, Line 13 less Line 11 of the annual statement and the sum of Lines (8.3), (12) and (13) on page XR017 – Underwriting Risk – Managed Care Credit.

Line (10) – Category 0 – No Federal Reinsurance or Risk Corridor Protection**.** Category 0 for Medicare Part D Coverage would be all claims during a period where neither the reinsurance coverage or risk corridor protection is provided.

Line (11) – Category 1 – Federal Reinsurance but no Risk Corridor Protection**.** Category 1 for Medicare Part D Coverage would be 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 (12) – Category 2a – No Federal Reinsurance but Risk Corridor Protection**.** Category 2a for Medicare Part D Coverage would be for all claims during a period when only the risk corridor protection is provided.

Line (13) – Category 3a – Federal Reinsurance and Risk Corridor Protection**.** Category 3a for Medicare Part D Coverage would be for all claims during a period when both reinsurance coverage and risk corridor protection are provided.

Line (14) – Sub-Total Paid Claims**.** The total paid claims for Medicare Part D Coverage, excluding supplemental benefits.

Line (16) – Weighted Average Managed Care Discount. These amounts are calculated by dividing the total weighted claims by the comparable sub-total claim payments. For Column (3), this is Column (3), Line (9) divided by Column (2), Line (9). For Column (4), this is Column (4) Line (14) divided by Column (2), Line (14).

Line (17) – Weighted Average Managed Care Risk Adjustment Factor**.** These are the credit factors that are carried back to the underwriting risk calculation. They are one minus the Weighted Average Managed Care Discount values in Line (16).

Not for Distribution

Lines (18) through (24) are the calculation of the weighted average factor for the Category 2 claims payments subject to withholds and bonuses. This table requires data from the PRIOR YEAR to compute the current year's discount factor. These do not apply to Medicare Part D coverage.

Line (18) – Withhold & Bonus Payments, ***prior year***. Enter the prior year's actual withhold and bonus payments.

Line (19) –Withhold & Bonuses Available, ***prior year***. Enter the prior year's withholds and bonuses that were available for payment in the prior year.

Line (20) – MCC Multiplier – Average Withhold Returned. Divides Line (18) by Line (19) to determine the portion of withholds and bonuses that were actually returned in the prior year.

Line (21) – Withholds & Bonuses Available, ***prior year***. Equal to Line (19) and is automatically pulled forward.

Line (22) – Claims Payments Subject to Withhold, ***prior year***. Claim payments that were subject to withholds and bonuses in the prior year. Equal to L(3) + L(4) of the managed care credit claims payment table FOR THE PRIOR YEAR.

Line (23) – Average Withhold Rate, ***prior year***. Divides Line (21) by Line (22) to determine the average withhold rate for the prior year.

Line (24) – MCC Discount Factor, Category 2. Multiplies Line (20) by Line (23) to determine the discount factor for Category 2 claims payments in the current year, based on the performance of the health entity's withhold/bonus program in the prior year.

CREDIT RISK
XR019

Reinsurance Ceded – L(1) through L(21)

There is a credit risk associated with recoverability of amounts due from reinsurers. However, reinsurance with wholly owned subsidiaries is exempt from RBC requirements because affiliate risk is addressed elsewhere in the Health RBC formula. The RBC requirement is 0.5 percent of the annual statement value of recoverables, unearned premiums, and other reserve credits.

The annual statement references for reinsurance recoverables (paid and unpaid) come from Schedule S, Part 2. The annual statement references for unearned premiums and other reserve credits are in Schedule S, Part 3. The annual statement reference for reinsurance recoverables related to the federal Affordable Care Act (ACA) should be reported in Line (4) and Line (10) and excluded from Line (3) and Line (9).

Capitations – L(22) through L(28)

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

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

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

Line (22) – Total Capitations Paid Directly to Providers. This is the amount reported in the Managed Care Credit Calculation page, Line (5).

Line (23) – Less Secured Capitations to Providers. Computed from the Capitations worksheet, this includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 8 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 following these instructions.

Line (24) – Capitations to Providers Subject to Credit Risk Charge. Line (22) minus Line (23).

Line (25) – Total Capitations to Intermediaries. From Line (6) and Line (7) of the Managed Care Credit Calculation page, this includes all capitation payments to intermediaries.

Line (26) – Less Secured Capitations to Intermediaries. Computed from the Capitations worksheet, this includes all capitations to providers that are secured by funds withheld or by acceptable letters of credit equal to 16 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 below these instructions.

CAPITATIONS TO PROVIDERS AND INTERMEDIARIES
CREDIT RISK EXEMPTION WORKSHEET

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	Sally Smith	125,000	5,000	0	4%	62,500
2	Jim Jones	50,000	5,000	0	10%	50,000
3	Dr. Doolittle	750,000	5,000	50,000	7%	687,500
4	Dr. Clements	25,000	0	0	0%	0
5	All others	2,500,000				0
19999	Total to Providers	3,450,000	xxx	xxx	xxx	800,000

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CAPITATIONS PAID TO UNREGULATED 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	Chicago Hope	1,000,000	100,000	0	10%	625.000
3	Bill's Clinic	4,500,000	0	500,000	11%	3,125,000
4	Joe's HMO	6,500,000	0	0	0%	0
5	All others	2,500,000				0
29999	Total to Unregulated Intermed	14,000,000	xxx	xxx	xxx	6,250,000

CAPITATIONS PAID TO REGULATED INTERMEDIARIES

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

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

The "Exempt Capitation" amount from Line 19999 of $800,000 would be reported on *L(23) Less Secured Capitations to Providers* in the Credit Risk page. The total of the "Exempt Capitation" amount from Line 29999 plus Line 39999 ($6,250,000+$2,550,000=$8,800,000) would be reported on L(26) *Less Secured Capitations to Intermediaries* in the Credit Risk page.

Line (27) – Capitations to Intermediaries Subject to Credit Risk Charge. L(25) minus L(26).

Line (28) – Capitation Credit Risk RBC. Sum of L(24) and L(27).

Other Receivables – L(29) through L(35)

There is an RBC requirement of 1 percent of the annual statement amount of investment income receivable and an RBC requirement of 5 percent of the annual statement amount for pharmaceutical rebates and amounts due from parents, subsidiaries, and affiliates, and aggregate write-ins for other than invested assets and an RBC

Not for Distribution

requirement of 19 percent of the annual statement amount for all other health care receivables reported in Lines (30.2) through (30.6). Enter the appropriate value in Lines (29) through (35).

Line (30.1). Pharmaceutical rebates are arrangements between pharmaceutical companies and reporting entities in which the reporting entities receive rebates based upon the drug utilization of its subscribers at participating pharmacies. These rebates are sometimes recorded as receivables by reporting entities using estimates based upon historical trends which should be adjusted to reflect significant variables involved in the calculation, such as number of prescriptions written/filled, type of drugs prescribed, use of generics vs. brand-name drugs, etc. In other cases, the reporting entity determines the amount of the rebate due based on the actual use of various prescription drugs during the accumulation period and then bills the pharmaceutical company. Oftentimes, a pharmacy benefits management company may determine the amount of the rebate based on a listing (of prescription drugs filled) prepared for the reporting entity's review. The reporting entity will confirm the listing and the pharmaceutical rebate receivable. Pharmaceutical rebates may relate to insured plans or uninsured plans. Only the receivable amount related to the insured plans should be reported on this line. Amount comes from annual statement Exhibit 3, Column 7, Line 0199999**.**

Line (30.2). Claim overpayments may occur as a result of several events, including but not limited to claim payments made in error to a provider. Reporting entities often establish receivables for claim overpayments. Amount comes from annual statement Exhibit 3, Column 7, Line 0299999**.**

Line (30.3). A health entity may make loans or advances to large hospitals or other providers. Such loans or advances are supported by legally enforceable contracts and are generally entered into at the request of the provider. In certain cases, loans or advances are paid monthly and are intended to represent one month of fee-for-service claims activity with the respective provider. Amount comes from annual statement Exhibit 3, Column 7, Line 0399999.

Line (30.4). A capitation arrangement is a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. In some instances, advances are made to a provider under a capitation arrangement in anticipation of future services. Amount comes from annual statement Exhibit 3, Column 7, Line 0499999**.**

Line (30.5). Risk sharing agreements are contracts between reporting entities and providers with a risk sharing element based upon utilization. The compensation payments for risk sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Amount comes from annual statement Exhibit 3, Column 7, Line 0599999.

Line (30.6)**.** Any other health care receivable not reported in Lines (30.1) through (30.5). Amount comes from annual statement Exhibit 3, Column 7, Line 0699999.

Line (31). Only include on this line amounts receivable related to pharmaceutical rebates on uninsured plans that are in excess of the liability estimated by the reporting entity for the portion of such rebates due to the uninsured accident and health plans.

BUSINESS RISK
XR021

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

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

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

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

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

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

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

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

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

ASO administrative fees, and reimbursements under ASC contracts for both administrative fees and the medical costs paid (ASC only), are included in the Non-Underwritten and Limited Risk Base.

> **NOTE**: The claim payments under ASC contracts SHOULD NOT be included in the Underwriting Risk section; they are reported in the Non-Underwritten and Limited Risk section only.

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

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

Guaranty Fund Assessment Risk – L(12)

If the reporting entity is subject to guaranty fund assessments in any state, there is an RBC requirement of 0.5 percent of the direct earned premiums subject to assessment in that state. Premiums subject to guaranty fund assessments that are reported in Schedule T should be aggregated and reported in Line (12).

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

Excessive growth risk is an important element of the Health RBC formula. Several recommendations for recognizing growth risk were considered, including growth in underwriting risk RBC by line of business, growth in premium, and growth in enrollment. However, these various measurements did not discriminate between reporting

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entities that had controlled growth with no accompanying increase in underwriting risk and those that were growing in both volume and risk. Additionally, the working group wanted to avoid imposing a growth charge that would unfairly discriminate against start-up companies where high growth rates were the norm. **Start-up health companies may consider use of their first year projected amounts (included in the projected RBC within the approved proforma) upon approval from their domiciliary state.**

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

To calculate excessive growth risk RBC in future years, enter the prior year's underwriting risk revenue [Prior Year Underwriting Risk – Experience Fluctuation Risk page, Column (7), Line (5)] in Line (13). The prior year's Net Underwriting Risk RBC [Prior Year Underwriting Risk – Experience Fluctuation Risk page, C(7), L(18)] is entered on Line (15). **For start-up companies report the first twelve months projected Underwriting Risk Revenue on Line (13) and the projected Net Underwriting Risk RBC on Line (15). The current year values are pulled automatically into Lines (14) and (16).** The growth rate in underwriting risk revenue plus 10 percent is multiplied times the prior year's Net Underwriting Risk RBC in Line (15) to establish the safe harbor level for the current year**.**

If there has been a merger or divestiture during the period, the values must be restated to reflect either the combination or division as if it had been in place at the beginning of the period. For example, if a merger takes place during 2017, the end-of-year 2016 underwriting risk revenue and the end-of-year 2016 net underwriting risk RBC must both be adjusted to include the merged entity as if it had been owned in the prior year.

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

GROWTH OPERATIONAL RISK INFORMATIONAL SECTION INSTRUCTIONS (FOR INFORMATIONAL PURPOSES ONLY) XR022

A growth operational risk component will be assessed based on the increase in gross premiums written (direct + assumed) from the prior year to the current year and will apply a risk factor to gross premiums that is in excess of 125 percent of prior year gross premiums. The gross premiums written will pull from the U & I Part 1, Column 1, Line 12. Negative results will be reported as a zero value. NOTE: Data will be collected to identify premiums assumed from subsidiaries and other affiliates subject to RBC requirements by the reporting entity to avoid duplication of RBC requirements captured in the H0 component.

The threshold for health growth risk is higher than the threshold for life and property and casualty growth risk due to the expectation that medical inflation will have a greater impact on health premiums than general inflation has on life or property and casualty premiums.

During testing, specific consideration will be given, and comparisons made, to the methodology behind the growth risk charge under H4 on Lines (13) through (19) on page XR021 – Business Risk of the Health RBC formula and any operational risk that is currently included therein.

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The line references in the Informational **Growth Risk** Section are generally self-explanatory. Where the formula lines include an annual statement reference, the instructions for that line are consistent with those in the annual statement for the referenced line unless otherwise noted.

FEDERAL ACA RISK ADJUSTMENT AND RISK CORRIDOR SENSITIVITY TEST

XR023

The federal ACA Risk Adjustment and Risk Corridor Sensitivity Test is used to adjust TAC for the risk adjustment receivable or payable and the risk corridor retrospective premium and reserve for rate credit or policy experience rating refunds. The sensitivity test identifies the potential impact to an insurer's RBC ratio due to the risk of misestimating the ACA risk adjustment and risk corridor by the insurer. The sensitivity test looks at both the risk of overestimation and underestimation by the insurer for both receivables and payables. Lines (1) through (11) look at the risk of overestimation while Lines (12) through (22) look at the risk of underestimation by decreasing and increasing the amount reported in the Notes to Financial Statement by 25 percent. The sensitivity test provides a "what if" scenario that has no effect on the risk-based capital amounts reported in the annual statement. The Health Risk-Based Capital (E) Working Group determined that a 25 percent change in the annual statement amount and a 50 percent factor should be used to calculate the effect of the misestimating the risk adjustment or risk corridor receivable and payable on the RBC ratio. The company can provide an explanation in the footnote if the company believes the factors are not appropriate, with an explanation as to why the factors are inappropriate.

Line (1) and Line (12) – Premium Adjustments Receivable Due to ACA Risk Adjustment. This is the amount reported in the annual statement Notes to Financial Statement 24E2a1. Column (2) would equal Column (1) multiplied by the sensitivity amount.

Line (2) and Line (13) – Premium Adjustments Payable Due to ACA Risk Adjustment. This is the amount reported in the annual statement Notes to Financial Statement 24E2a3. Column (2) would equal Column (1) multiplied by the sensitivity amount.

Line (3) and Line (14) – Total ACA Risk Adjustments Receivable and Payable. Line (3) would be equal to Line (2) minus Line (1) and Line (14) would be equal to Line (13) minus Line (12).

Line (4) and Line (15) – Accrued Retrospective Premium Due to ACA Risk Corridors. This is the amount reported in the annual statement Notes to Financial Statement 24E2c1. Column (2) would equal Column (1) multiplied by the sensitivity amount).

Line (5) and Line (16) – Reserve for Rate Credits or Policy Experience Rating Refunds Due to ACA Risk Corridors. This is the amount reported in the annual statement Notes to Financial Statement 24E2c2. Column (2) would equal Column (1) multiplied by the sensitivity amount.

Line (6) and Line (17) – Total ACA Risk Corridor Retrospective Premium and Rate Credits or Policy Experience Rating Refunds. Line (6) is equal to Line (5) minus Line (4) and Line (17) is equal to Line (16) minus Line (15).

Line (7) and Line (18) – Total Risk Adjustment and Risk Corridor. The absolute value of Line (7), Column (3) is equal to Line (3) plus Line (6). The absolute value of Line (18), Column (3) is equal to Line (14) plus Line (17).

Line (8) and Line (19) – Page XR026, Total Adjusted Capital, Post Deferred Tax. Line (6)

Line (9) and Line (20) – Total Adjusted Capital Stressed for Risk Adjustments. Line (9) is equal to Line (8) minus Line (7) and Line (20) is equal to Line (19) minus Line (18).

Line (10) and Line (21) – Authorized Control Level RBC. Page XR027 – Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)

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Line (11) and Line (22) – ACA Risk Adjusted ACL RBC Ratio. Line (11) is equal to Line (9) divided by Line (10) and Line (22) is equal to Line (20) divided by Line (21).

Footnote - If it is the belief of the company that the factors are not appropriate, provide an explanation as to why the factors are inappropriate. Provide an explanation as why the company believes that the factors are inappropriate.

COVARIANCE CALCULATION

XR024–XR025

The purpose of the Health RBC formula is to estimate the minimum risk-based capital required to absorb losses that can be caused by a series of catastrophic financial events. However, it is extremely unlikely that all such losses will occur simultaneously. The covariance formula adjusts the combined effect of the H0, H1, H2, H3, and H4 risks so that the combination of risks is less than the sum of the parts. Statistically, this assumes that the H1, H2, H3 and H4 risks are uncorrelated. The H0 risk of subsidiaries is added to the total under the assumption that the risk of the subsidiaries is highly correlated with the risk of the parent, so that if the parent were to experience severe financial distress, the subsidiaries would also be adversely affected.

The components of the RBC after Covariance Formula are:

H0 – Asset Risk – Affiliates with RBC
H1 – Asset Risk – Other
H2 – Underwriting Risk
H3 – Credit Risk
H4 – Business Risk

The covariance formula is **applied before adding operational risk on Line (37) on XR025**:

RBC after Covariance **Before Operational Risk** = Square Root of $(H1^2 + H2^2 + H3^2 + H4^2) + H0$

Operational Risk:
Operational risk is defined as the risk of financial loss resulting from operational events, such as the inadequacy or failure of internal systems, personnel, procedures or controls, as well as external events. Operational risk includes legal risk but excludes reputational risk and risk arising from strategic decisions. Operational risk has been identified as a risk that should be explicitly addressed in the RBC formulas. The Operational Risk charge is intended to account for operational risks that are not already reflected in existing risk categories.

An operational risk charge will be reported on Line 38 using a percentage of RBC or "add-on" approach that will apply a risk factor of 0.00% to the amount reported in Line (37) - RBC after Covariance Before Operational Risk reported on page XR025.

Total RBC After Covariance including Operational Risk will be reported in Line (39) as the sum of lines (37) and (38).

Authorized Control Level RBC is computed from the RBC after Covariance and is set at 50 percent of RBC after Covariance **including Operational Risk**.

Company Action Level RBC is 200 percent of Authorized Control Level RBC. Regulatory Action Level RBC is 150 percent of Authorized Control Level RBC. Mandatory Control Level RBC is 70 percent of Authorized Control Level RBC.

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TOTAL ADJUSTED CAPITAL
XR026

Total Adjusted Capital (TAC) includes the statutory capital and surplus/total net worth of the reporting entity plus adjustments. Adjustments are made in recognition of statutory accounting conventions that tend to understate the actual capital and surplus that a company possesses in case of liquidation.

There are additions to TAC for the Asset Valuation Reserve and half of the dividend liability of any Life/Health subsidiary. These reserves understate the surplus of the subsidiary and must be added back to the parent's TAC. The annual statement amount of any Life/Health subsidiary's AVR should be reported on Line (2), prorated for percent of ownership. Dividend liability for life insurance subs should be reported on Line (3). The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

Subsidiary amounts are included, as appropriate, recognizing that the subsidiary's surplus is included within the surplus of the parent. For Property and Casualty subsidiaries, there is a reduction in TAC equal to non-tabular discounts and medical discounts reported as tabular that the subsidiary may claim. Discounting of loss reserves is not widely practiced in Property/Casualty accounting. Therefore, any of these discounts being used by a Property/Casualty subsidiary to bolster the subsidiary's surplus must be removed to ensure a level playing field among companies subject to RBC. If the reporting entity owns a Property/Casualty subsidiary that has non-tabular discounts or medical discounts reported as tabular, the full amount of the reserve discount should be entered on Lines (4) and (5). Nontabular reserve discounts reported in Line (5) come from the subsidiary's Schedule P Part 1. Tabular reserves in Line (4) come from the Notes to the Financial Statement of the affiliate's annual statement.

Lines (7) through (11) are used for a sensitivity test. The sensitivity test provides a "what if" scenario eliminating deferred tax assets and deferred tax liabilities from the calculation of Total Adjusted Capital. The sensitivity test has no effect on the risk-based capital amounts reported in the annual statement.

DTA should include only the admitted portion of the DTA inside amount, for Line (9). Line (9) should only include the admitted portion of insurance subsidiaries deferred tax assets that are subject to RBC and whose RBC formula excludes DTAs and DTLs from the TAC calculation.

Lines (16) through (19) are used for the federal ACA fee sensitivity test. The ACA fee sensitivity test provides a "what if" scenario eliminating the ACA fee from the Calculation of Total Adjusted Capital. The ACA fee included on Line (16) is the estimated data year amount that is to be paid in the fee year. The ACA fee sensitivity test has no effect on the risk-based capital amounts reported in the annual statement. Column (2), Line (19) should equal the annual statement Notes to Financial Statement, Note 22B, Column 1.

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL
XR027

As long as the Total Adjusted Capital (TAC) shown on Line (1) of Comparison of Total Adjusted Capital to Risk-Based Capital section exceeds the Company Action Level Risk-Based Capital (CALRBC) shown on Line (2), the reporting entity has passed the minimum capital adequacy test of the Health RBC formula. However, that does not necessarily mean that the reporting entity is financially sound. The RBC formula is just one of many regulatory tools used by regulators to evaluate the financial health of regulated entities. Although healthy companies rarely fail the RBC test, weak companies often do pass the RBC test, although weak companies will eventually fail the test if their problems continue.

Those organizations that do trigger one of the RBC action levels are generally subject to regulatory action by the state of domicile, or by a non-domiciliary state where the reporting entity does business, under the provisions of state law. The NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315) provides for an

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increasingly stringent regulatory response for companies that trigger one of the RBC action levels. Those action levels are (1) Company Action Level, (2) Regulatory Action Level, (3) Authorized Control Level and (4) Mandatory Control Level.

The four RBC action levels trigger an increasingly stringent level of regulatory response for those companies that trigger one of the action levels. Lines (2) through (6) will be calculated automatically by the program. One of the following action levels will appear on Line (6).

- Company Action Level (TAC is between 150 percent and 200 percent of the Authorized Control Level RBC).
- Regulatory Action Level (TAC is between 100 percent and 150 percent of the Authorized Control Level RBC).
- Authorized Control Level (TAC is between 70 percent and 100 percent of the Authorized Control Level RBC).
- Mandatory Control Level (TAC less than 70 percent of the Authorized Control Level RBC).

Company Action Level requires the reporting entity to prepare and submit to the insurance commissioner a comprehensive financial plan. The plan identifies the conditions that contributed to the company's financial condition, contains proposals to correct the company's financial problems, and provides projections of the company's financial condition, both with and without the proposed corrections.

Regulatory Action Level requires the reporting entity to submit a comprehensive financial plan. In addition, the insurance commissioner may perform any examinations or analysis of the reporting entity's business and operations that it deems necessary, and issue any appropriate corrective orders to address the company's financial problems.

Authorized Control Level authorizes the insurance commissioner to take whatever regulatory actions considered necessary to protect the best interest of the policyholders and creditors of the reporting entity which may include the actions necessary to cause the insurer to be placed under regulatory control (i.e., rehabilitation or liquidation).

Mandatory Control Level requires the insurance commissioner to place the reporting entity under regulatory control.

Trend Test

A company whose RBC ratio is between 200 percent and 300 percent and combined ratio is greater than 105 percent could trigger a Company Action Level RBC regulatory action per the Trend Test. The calculation is informational-only until state statutes are implemented so that the trend test would trigger a Company Action Level RBC regulatory action per the statute.

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APPENDIX 1 – COMMONLY USED TERMS

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

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

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

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

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

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

Admitted Assets – Assets recognized and accepted by a state commissioner, director or superintendent in determining the solvency of the reporting entity.

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

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

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

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Health Care Delivery Assets – Land, buildings, equipment and supplies used directly to deliver health care to members as defined by *SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities.*

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

Health Entity – Any issuer of a policy or contract providing or offering to provide a plan of Comprehensive Medical and Hospital; Medicare Supplement; Dental/Vision; Stand-Alone Medicare Part D Coverage or Other health benefits through individual or group plans and which files the Health Annual Statement blank. The term Health Entity was previously expanded and replaced HMO beginning in the 2015 instructions.

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

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

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

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

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

Non-Admitted Assets – Assets that are not accepted by a state commissioner or superintendent in determining the solvency of the reporting entity.

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

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

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

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

Regulated Intermediary – An intermediary (affiliated or not) subject to state regulation and files the Health RBC formula with the state. (see also Intermediary)

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

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

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

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

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APPENDIX 2 – COMMONLY USED TERMS FOR MEDICARE PART D COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Affix Bar Code Here

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COMPANY INFORMATION PAGE (JURAT)
Health Risk-Based Capital
For the Year Ending December 31, 2017

(A) Company Name _____

(B) NAIC Group _____ (C) NAIC Company Code _____ (D) Employer's ID Number _____

(E) Organized under the Laws of the State of _____

Contact Person for Health Risk-Based Capital:

(F) First Name (G) Middle (H) Last Name

(I) Mail Address of Contact Person
(Street and Number or P.O. Box)

(J) City (K) State (L) Zip

(M) Phone Number Extension

(N) Email Address of RBC Contact Person

(O) Date Prepared _____

(P) Preparer (if different than Contact)
First Middle Last

(Q) Is this an Original, Amended, or Refiling? (O, A, R)

(Q1) If Amended, Amendment Number:

(R) Were any items that come directly from the annual statement entered manually to prepare this filing? (Yes/No)

(S) Was the entity in business for the entire reporting year?

Officers: Name

Title

Each says that they are the above described officers of the said insurer, and that this risk-based capital report is a true and fair representation of the company affairs and has been completed in accordance with the NAIC instructions, according to the best of their information, knowledge and belief, respectively.

_____ _____ _____
(Signature) (Signature) (Signature)

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AFFILIATED COMPANIES RISK - DETAILS

	(1) Name of Affiliate	(2) Affiliate Type Code	(3) NAIC Company Code or Alien ID Number	(4) Affiliate's **RBC after Covariance Before Basic Operational Risk** XR025 Line (37) **PR032 Line (73)** LR031 Line (67) **+ (70)**	(5) Book/Adj Carrying Value of Affiliate's Common Stock	(6) Valuation Basis of Col (5) F - Fair A - All Other	(7) Total Value of Affiliate's Outstanding Common Stock	(8) Total Statutory Surplus of Affiliate Subject to RBC	(9) Book/Adj Carrying Value of Affiliate's Preferred Stock	(10) Total Value of Affiliate's Outstanding Preferred Stock	(11) Percent Owned (Cols 5 + 9) / (Cols 7 + 10)	(12) H0 Component RBC Required	(13) H1 Component RBC Required
(01)													
(02)													
(03)													
(04)													
(05)													
(06)													
(07)													
(08)													
(09)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													
(9999999)	Total	XXX	XXX			XXX					XXX		

Denotes items that must be manually entered on filing software.

Logic

If Col (2) < 5 and Col (6) = F Do Calculation

Calculation

Col (12) = Min [Col (4) x Col (11), Col (8) x Col (11)]

If Col (5) + Col (9) > Max [Col (4) x Col (11), Col (8) x Col (11)] then

Col (13) = Max{[Col (5) + Col (9) - Col (8) x Col (11)] x .25 [Col (5) + Col (9) - Col (8)] x Col (11)}

If Col (4) x Col (11) > Col (5) + Col (9) > Col (8) x Col (11) then

Col (13) = Col (5) + Col (9) - Col (8) x Col (11)

Otherwise

Col (13) = 0

Col (12) and (13) cannot be less than 0

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AFFILIATED COMPANIES RISK

	Type of Affiliate	Type Code	Basis	(1) RBC	(2) Count
(1)	Directly Owned Insurer Subject to RBC	1	Affiliate's RBC*		
(2)	Indirectly Owned Insurer Subject to RBC	2	Affiliate's RBC*		
(3)	Directly Owned Health Entity Subject to RBC	3	Affiliate's RBC*		
(4)	Indirectly Owned Health Entity Subject to RBC	4	Affiliate's RBC*		
(5)	Investment Affiliates	5	0.300		
(6)	Holding Company Excess of Subsidiaries	6	0.300		
(7)	Directly Owned Alien Insurer	7	1.000		
(8)	Indirectly Owned Alien Insurers	8	1.000		
(9)	Investment in Parent	9	0.300		
(10)	Other Affiliates	10	0.300		
(11)	Fair Value Excess Affiliate Common Stock	11	Total of Type Codes 1 through 4 of XR002, Col 13		

* Capped at carrying value on the parent's statement

Denotes items that must be manually entered on filing software.

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CROSSCHECKING FOR AFFILIATED INVESTMENTS
Schedule D, Part 6, Section 1

Not for Distribution

Preferred Stock

		Annual Statement Line Number	(1) Annual Stmt Total Preferred Stock	(2) Total From RBC Report	(3) Difference
(1)	Parent	0199999			
(2)	U.S. P&C Insurers	0299999		XXX	XXX
(3)	U.S. Life Insurers	0399999		XXX	XXX
(4)	U.S. Health Entity	0499999		XXX	XXX
(5)	Total P&C, Life and Health Insurers		-	-	-
(6)	Alien Insurer	0599999			
(7)	Non-Insurer Which controls Insurers	0699999			
(8)	Investment Affiliates	0799999			
(9)	Other Affiliates	0899999			
(10)	Subtotal	0999999			

Common Stock

		Annual Statement Line Number	(1) Annual Stmt Total Common Stock	(2) Total From RBC Report	(3) Difference
(11)	Parent	1099999			
(12)	U.S. P&C Insurers	1199999		XXX	XXX
(13)	U.S. Life Insurers	1299999		XXX	XXX
(14)	U.S. Health Entity	1399999		XXX	XXX
(15)	Total P&C, Life and Health Insurers		-	-	-
(16)	Alien Insurer	1499999			
(17)	Non-Insurer Which Controls Insurers	1599999			
(18)	Investment Affiliates	1699999			
(19)	Other Affiliates	1799999			
(20)	Subtotal	1899999	-	-	-

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OFF-BALANCE SHEET AND OTHER ITEMS

		Annual Statement Source	(1) Bk/Adj Carrying Value	(2) Factor	(3) RBC Requirement	(4) Yes/No Response
	Non-Controlled Assets					
(1)	Loaned to Others - Conforming Securities Lending Programs	General Interrogatories Part 1 Line 24.05		0.002		
(2)	Loaned to Others - Securities Lending Programs - Other	General Interrogatories Part 1 Line 24.06		0.010		
(3)	Subject to Repurchase Agreements	General Interrogatories Part 1 Line 25.21		0.010		
(4)	Subject to Reverse Repurchase Agreements	General Interrogatories Part 1 Line 25.22		0.010		
(5)	Subject to Dollar Repurchase Agreements	General Interrogatories Part 1 Line 25.23		0.010		
(6)	Subject to Reverse Dollar Repurchase Agreements	General Interrogatories Part 1 Line 25.24		0.010		
(7)	Placed Under Option Agreements	General Interrogatories Part 1 Line 25.25		0.010		
(8)	Letter Stock or Securities Restricted as to Sale - Excluding FHLB Capital Stock	General Interrogatories Part 1 Line 25.26		0.010		
(9)	FHLB Capital Stock	General Interrogatories Part 1 Line 25.27		0.010		
(10)	On Deposit with States	General Interrogatories Part 1 Line 25.28		0.010		
(11)	On Deposit with Other Regulatory Bodies	General Interrogatories Part 1 Line 25.29		0.010		
(12)	Pledged as Collateral - Excluding Collateral Pledged to an FHLB	General Interrogatories Part 1 Line 25.30		0.010		
(13)	Pledged as Collateral to FHLB (including assets backing funding agreements)	General Interrogatories Part 1 Line 25.31		0.010		
(14)	Other	General Interrogatories Part 1 Line 25.32		0.010		
(15)	Total Non-Controlled Assets	Sum of Lines (1) through (14)				
(16)	Guarantees for Affiliates	Notes to Financial Statements 14A(03C1), Column 2		0.010		
(17)	Contingent Liabilities	Notes to Financial Statements 14A(1), Column 2		0.010		
(18)	Is the entity responsible for filing the U.S. Federal income tax return for the reporting insurer a regulated insurance company?	"Yes", "No" or "N/A" in Column (4)				
(19)	SSAP No. 101 Paragraph 11a Deferred Tax Assets	Notes to Financial Statements, Item 9A2(a), Column 3		†		
(20)	SSAP No. 101 Paragraph 11b Deferred Tax Assets	Notes to Financial Statements, Item 9A2(b), Column 3		0.010		
(21)	Total Miscellaneous Off-Balance Sheet and Other Items	L(15) + L(16) + L(17) + L(19) + L(20)				

† If Line (18) Column (4) is "Yes", then the factor is 0.005. If Line (18) Column (4) is "No", then the factor is 0.010. If Line (18) Column (4) is "N/A", then the factor is 0.000.

Denotes items that must be manually entered on filing software.

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

Asset Category	Annual Statement Source	(1) Off-Balance Sheet Collateral Book/Adjusted Carrying Value	(2) Schedule DL, Part 1 Book/Adjusted Carrying Value	(3) Subtotal	Factor	(4) RBC Requirement
Fixed Income Assets						
Bonds						
(1) NAIC 01 - U.S. Government - Direct and Guaranteed	Company Records				0.000	
(2) Other NAIC 01 Bonds	Company Records				0.003	
(3) Total NAIC 01 Bonds	Line (1) + Line (2)					
(4) Total NAIC 02 Bonds	Company Records				0.010	
(5) Total NAIC 03 Bonds	Company Records				0.020	
(6) Total NAIC 04 Bonds	Company Records				0.045	
(7) Total NAIC 05 Bonds	Company Records				0.100	
(8) Total NAIC 06 Bonds	Company Records				0.300	
(9) Total Bonds	L(3)+L(4)+L(5)+L(6)+L(7)+L(8)					
Equity Assets						
Preferred Stock - Unaffiliated						
(10) NAIC 01 Unaffiliated Preferred Stock	Company Records				0.003	
(11) NAIC 02 Unaffiliated Preferred Stock	Company Records				0.010	
(12) NAIC 03 Unaffiliated Preferred Stock	Company Records				0.020	
(13) NAIC 04 Unaffiliated Preferred Stock	Company Records				0.045	
(14) NAIC 05 Unaffiliated Preferred Stock	Company Records				0.100	
(15) NAIC 06 Unaffiliated Preferred Stock	Company Records				0.300	
(16) Total Unaffiliated Preferred Stock	Sum of Lines (10) through (15)					
(17) Common Stock	Company Records				0.150	
(18) Real Estate and Property & Equipment Assets	Company Records				0.100	
(19) Other Invested Assets	Company Records				0.200	
(20) Mortgage Loans on Real Estate	Company Records				0.050	
(21) Cash, Cash Equivalents and Short-Term Investments (Not reported on Bonds above)	Company Records				0.003	
(22) Total	L(9)+L(16)+L(17)+L(18)+L(19)+L(20)+L(21)					

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FIXED INCOME ASSETS

		Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
BONDS					
(1)	NAIC 01 - U.S. Government - Direct and Guaranteed	Sch D, Pt 1A, Sn 1, Col 7, Line 1.1			
(2)	Total NAIC 01 Bonds	Sch D, Pt 1A, Sn 1, Col 7, Line 10.1 - Line 7.1			
(3)	Other NAIC 01 Bonds	L(2) - L(1)		0.0030	
(4)	Total NAIC 02 Bonds	Sch D, Pt 1A, Sn 1, Col 7, Line 10.2 - Line 7.2		0.0100	
(5)	Total NAIC 03 Bonds	Sch D, Pt 1A, Sn 1, Col 7, Line 10.3 - Line 7.3		0.0200	
(6)	Total NAIC 04 Bonds	Sch D, Pt 1A, Sn 1, Col 7, Line 10.4 - Line 7.4		0.0450	
(7)	Total NAIC 05 Bonds	Sch D, Pt 1A, Sn 1, Col 7, Line 10.5 - Line 7.5		0.1000	
(8)	Total NAIC 06 Bonds	Sch D, Pt 1A, Sn 1, Col 7, Line 10.6 - Line 7.6		0.3000	
(9)	Total Bonds				
MISCELLANEOUS FIXED INCOME ASSETS					
(10)	Cash	Page 2, Line 5, inside amount 1		0.0030	
(11)	Cash Equivalents	Page 2, Line 5, inside amount 2			
(12)	Less: Cash Equivalent, Bonds included in Schedule D, Part 1A	Sch E Pt 2, **C7**, L8399999, in part			
(13)	**Less: Exempt Money Market Mutual Funds***	**Sch E Pt 2, C7, L8599999**			
(14)	Net Cash Equivalents	L (11) - L (12) **- L(13)**		0.0030	
(15)	Short-Term Investments	Page 2, Line 5, inside amount 3			
(16)	Short-Term Bonds *	Sch DA, Pt 1, **Col 7**, L8399999			
(17)	Total Other Short-Term Investments	**L(15) - L(16)**		0.0030	
(18)	Mortgage Loans - First Liens	Page 2, Col 3, Line 3		0.0500	
(19)	Mortgage Loans - Other Than First Liens	Page 2, Col 3, Line 4.2		0.0500	
(20)	Receivable for Securities	Page 2, Col 3, Line 9		0.0240	
(21)	Aggregate write-ins for invested assets	Page 2, Col 3, Line 10		0.0500	
(22)	Collateral Loans	Included in Page 2, Col 3, Line 8		0.0500	
(23)	NAIC 01 Working Capital Finance Investments	Notes to Financial Statement 5A(01a), Col. 3		0.0038	
(24)	NAIC 02 Working Capital Finance Investments	Notes to Financial Statement 5A(01b), Col. 3		0.0125	
(25)	Other Long-Term Invested Assets Excluding Collateral Loans and Working Capital Finance Investments	Included in Page 2, Col 3, Line 8		0.2000	
(26)	Federal Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3199999 + 3299999		0.0014	
(27)	Federal Non-Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3399999 + 3499999		0.0260	
(28)	State Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3599999 + 3699999		0.0014	
(29)	State Non-Guaranteed Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3799999 + 3899999		0.0260	
(30)	All Other Low Income Housing Tax Credits	Schedule BA Part 1, Column 12 Lines 3999999 + 4099999		0.0150	
(31)	Total Other Long-Term Invested Assets (Page 2, Col 3, Line 8)	**L(22)+L(23)+L(24)+L(25)+L(26)+L(27)+L(28)+L(29)+L(30)**			
(32)	Derivatives	Page 2, Col 3, Line 7			
(33)	Total Fixed Income Assets RBC	L(9)+L(10)**+L(14)+L(17)+L(18)+L(19)+L(20)+L(21)+L(31)+L(32)**			

Denotes items that must be manually entered on filing software.

* These bonds appear in Schedule D Part 1A Section 1 and are already recognized in the Bond portion of the formula.

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REPLICATION (SYNTHETIC ASSET) TRANSACTIONS AND MANDATORY CONVERTIBLE SECURITIES

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	(1) RSAP Number	(2) Type	(3) CUSIP	(4) Description of Asset(s)	(5) NAIC Designation or Other Description of Asset	(6) Value of Asset	(7) RBC Requirement
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
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(23)							
(24)							
(25)							
(26)							
(27)							
(28)							
(29)							
(30)							
(31)							
(32)							
(33)							
(34)							
(35)							
(9999999)	XXX	XXX	XXX	Total	XXX		

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EQUITY ASSETS

		Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
PREFERRED STOCK - UNAFFILIATED					
(1)	NAIC 01 Preferred Stock	Included in Sch D, Pt 2, Sn 1		0.003	
(2)	NAIC 02 Preferred Stock	Included in Sch D, Pt 2, Sn 1		0.010	
(3)	NAIC 03 Preferred Stock	Included in Sch D, Pt 2, Sn 1		0.020	
(4)	NAIC 04 Preferred Stock	Included in Sch D, Pt 2, Sn 1		0.045	
(5)	NAIC 05 Preferred Stock	Included in Sch D, Pt 2, Sn 1		0.100	
(6)	NAIC 06 Preferred Stock	Included in Sch D, Pt 2, Sn 1		0.300	
(7)	Subtotal - Unaffiliated Preferred Stock	Sum of Lines (1) through (6)			
(Should equal Page 2, Col 3, Line 2.1 less Sch D Sum, Col 1, Line 8)					
HYBRID SECURITIES - UNAFFILIATED					
(8)	NAIC 01 Hybrid Securities	Sch D, Pt 1A, Sn 1, Col 7, Line 7.1		0.003	
(9)	NAIC 02 Hybrid Securities	Sch D, Pt 1A, Sn 1, Col 7, Line 7.2		0.010	
(10)	NAIC 03 Hybrid Securities	Sch D, Pt 1A, Sn 1, Col 7, Line 7.3		0.020	
(11)	NAIC 04 Hybrid Securities	Sch D, Pt 1A, Sn 1, Col 7, Line 7.4		0.045	
(12)	NAIC 05 Hybrid Securities	Sch D, Pt 1A, Sn 1, Col 7, Line 7.5		0.100	
(13)	NAIC 06 Hybrid Securities	Sch D, Pt 1A, Sn 1, Col 7, Line 7.6		0.300	
(14)	Subtotal - Hybrid Securities	Sum of Lines (8) through (13)			
(15)	Total Unaffiliated Preferred Stock and Hybrids	Line (7) + Line (14)			
COMMON STOCK - UNAFFILIATED					
(16)	Federal Home Loan Bank Stock	Company Records		0.023	
(17)	Non-Government Money Market Funds	**Schedule E, Part 2, Column 7, Line 8699999**		**0.000**	
(18)	Total Common Stock	Sch D, Summary, Col 1, Line 25			
(19)	Affiliated Common Stock	Sch D, Summary, Col 1, Line 24			
(20)	Other Unaffiliated Common Stock	L(18)-L(16)-L(17)-L(19)	$0	0.150	
(21)	Total Unaffiliated Common Stock	L(16)+L(17)+L(20)	$0		

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PROPERTY & EQUIPMENT ASSETS

		Annual Statement Source	(1) Bk/Adj Carrying Value	Factor	(2) RBC Requirement
(1)	Properties Occupied by the Company	Page 2, Col 3, Line 4.1		0.100	
(2)	Encumbrances (Property Occupied by the Company)	Page 2, Line 4.1, inside amount		0.100	
(3)	Properties Held for the Production of Income	Page 2, Col 3, Line 4.2		0.100	
(4)	Encumbrances (Property Held for Production of Income)	Page 2, Line 4.2, inside amount		0.100	
(5)	Properties Held for Sale	Page 2, Col 3, Line 4.3		0.100	
(6)	Encumbrances (Property Held for Sale)	Page 2, Line 4.3, inside amount		0.100	
(7)	Furniture and Equipment	L(7.1) + L(7.2) (should equal Page 2, Col 3, Line 21)			
(7.1)	HC Delivery Subject to Statutory Acct Depreciation Limits	Company Records		0.100	
(7.2)	All Other Furniture and Equipment	Company Records		0.100	
(8)	EDP Equipment and Software	Page 2, Col 3, Line 20		0.100	
(9)	Total Property and Equipment	L(1)+L(2)+L(3)+L(4)+L(5)+L(6)+ L(7.1)+L(7.2)+L(8)			

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ASSET CONCENTRATION

	(1) Issuer Name	(2) Bk/Adj Carrying Value	Factor	(3) Additional RBC
(1)	NAIC 02 Unaffiliated Bonds		0.0100	
(2)	NAIC 03 Unaffiliated Bonds		0.0200	
(3)	NAIC 04 Unaffiliated Bonds		0.0450	
(4)	NAIC 05 Unaffiliated Bonds		0.1000	
(5)	Collateral Loans		0.0500	
(6)	Mortgages		0.0500	
(7)	NAIC 02 Preferred Stock		0.0100	
(8)	NAIC 03 Preferred Stock		0.0200	
(9)	NAIC 04 Preferred Stock		0.0450	
(10)	NAIC 05 Preferred Stock		0.1000	
(11)	NAIC 02 Hybrid Securities		0.0100	
(12)	NAIC 03 Hybrid Securities		0.0200	
(13)	NAIC 04 Hybrid Securities		0.0450	
(14)	NAIC 05 Hybrid Securities		0.1000	
(15)	Other Long-Term Invested Assets		0.1000	
(16)	NAIC 02 Working Capital Finance Investments		0.0125	
(17)	Federal Guaranteed Low Income Housing Tax Credits		0.0014	
(18)	Federal Non-Guaranteed Low Income Housing Tax Credits		0.0250	
(19)	State Guaranteed Low Income Housing Tax Credits		0.0014	
(20)	State Non-Guaranteed Low Income Housing Tax Credits		0.0250	
(21)	All Other Low Income Housing Tax Credits		0.0150	
(22)	Unaffiliated Common Stock		0.1500	
(23)	Total of Issuer = Lines (1) through (22)			

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Note: Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calcuated as the sum of issuers 1-10 by asset type.

Denotes items that must be manually entered on filing software.

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UNDERWRITING RISK

Experience Fluctuation Risk

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

TIERED RBC FACTORS*						
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$0 - $3 Million	0.150	0.105	0.120	0.251	0.130	0.130
$3 - $25 Million	0.150	0.067	0.076	0.151	0.130	0.130
Over $25 Million	0.090	0.067	0.076	0.151	0.130	0.130

ALTERNATE RISK CHARGE**

** The Line (15) Alternate Risk Charge is calculated as follows:						
LESSER OF:	$1,500,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$50,000 or 2 x Maximum Individual Risk	$150,000 or 6 x Maximum Individual Risk	$5[illegible],000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013.

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

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

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UNDERWRITING RISK (FOR INFORMATIONAL PURPOSES ONLY)

Experience Fluctuation Risk

			(1)	(2)	(3)	(4)	(5)	(6)	(7)
		Line of Business	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health	Total
(1)		Individual Premium		XXX		XXX	XXX	XXX	
(2)		Small Group Premium		XXX		XXX	XXX	XXX	
(3)		Large Group Premium		XXX		XXX	XXX	XXX	
(4)	†	Total Premium							
(5)	†	Title XVIII-Medicare		XXX	XXX	XXX	XXX	XXX	
(6)	†	Title XIX-Medicaid		XXX	XXX	XXX	XXX	XXX	
(7)	†	Other Health Risk Revenue		XXX				XXX	
(8)		Underwriting Risk Revenue = L(4)+L(5)+L(6)+L(7)							
(9)		Individual Net Incurred Claims		XXX		XXX	XXX	XXX	
(10)		Small Group Net Incurred Claims		XXX		XXX	XXX	XXX	
(11)		Large Group Net Incurred Claims		XXX		XXX	XXX	XXX	
(12)	†	Title XVIII-Medicare Net Incurred Claims		XXX	XXX	XXX	XXX	XXX	
(13)	†	Title XIX-Medicaid Net Incurred Claims		XXX	XXX	XXX	XXX	XXX	
(14)		Other Health Net Incurred Claims		XXX				XXX	
(15)	†	Total Net Incurred Claims						XXX	
(16)	†	Fee-For-Service Offset		XXX				XXX	
(17)		Underwriting Risk Incurred Claims = L(15)-L(16)						XXX	
(18)		Individual Underwriting Risk Claims Ratio = L(9)/L(1)		XXX		XXX	XXX	XXX	XXX
(19)		Small Group Underwriting Risk Claims Ratio = L(10)/L(2)		XXX		XXX	XXX	XXX	XXX
(20)		Large Group Underwriting Risk Claims Ratio = L(11)/L(3)		XXX		XXX	XXX	XXX	XXX
(21)		Title XVIII-Medicare Underwriting Risk Claims Ratio = L(12)/L(5)		XXX	XXX	XXX	XXX	XXX	XXX
(22)		Title XIX-Medicaid Underwriting Risk Claims Ratio = L(13)/L(6)		XXX	XXX	XXX	XXX	XXX	XXX
(23)		Other Health Underwriting Risk Claims Ratio = L(14)/L(7)		XXX				XXX	XXX
(24)		Underwriting Risk Claims Ratio = For Column (1) through (5), L(17)/L(8)						1.000	XXX
(25)		Underwriting Risk Factor*					0.130	0.130	XXX
(26)		Base Underwriting Risk RBC = L(8) x L(24) x L(25)							
(27)		Managed Care Discount Factor						XXX	XXX
(28)		RBC after Managed Care Discount = L(26) x L(27)						XXX	
(29)	†	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(30)		Alternate Risk Charge **						XXX	XXX
(31)		Alternate Risk Adjustment						XXX	XXX
(32)		Net Alternate Risk Charge***						XXX	
(33)		Net Underwriting Risk RBC (MAX{L(28),L(32)}) for Columns (1) through (5), Column (6), L(26)							

TIERED RBC FACTORS *

	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
$0 - $3 Million	0.150	0.105	0.120	0.251	0.130	0.130
$3 - $25 Million	0.150	0.067	0.076	0.251	0.130	0.130
Over $25 Million	0.090	0.067	0.076	0.151	0.130	0.130

ALTERNATE RISK CHARGE**

The Line (30) Alternate Risk Charge is calculated as follows:						
LESSER OF:	1,500,000 or 2 x Maximum Individual Risk	50,000 or 2 x Maximum Individual Risk	50,000 or 2 x Maximum Individual Risk	150,000 or 6 x Maximum Individual Risk	50,000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR013-A

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

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

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XR012-A Footnotes

Footnote 1a: If your company is unable to complete this schedule, please provide an explanation.
Footnote 1b: If your company allocated Line (4) and (15) into Lines (1) through (3) and Lines (9) through (11), describe the basis of the allocation
Footnote 1c: Does the allocation basis reflect estimated impacts of the ACA reinsurance, risk adjustments and risk corridor? Yes_____ No_____. Explain: _____
Footnote 2: Please explain how your company defines small group for the purposes of this form and what is the source of your company's data._____
Footnote 3±: List the percentage of individual premium earned that are written inside of the exchange (a)_____ and the percentage of individual premiums earned that are written outside of the exchange (b)_____. List the percentage of individual incurred claims on policies written inside of the exchange (c)_____ and the percentage of individual incurred claims on policies written outside of the exchange (d)_____. Footnote 4: If your company had to allocate the accruals for premium and claims inside and outside of the exchanges included in Footnote 3, explain the methodology that your company used to allocate thes accruals.

± The percentage breakout of Line (1), Column (1) should equal 100% of Footnote 3(a) and 3(b) and the percentage breakout of Line (9), Column (1) should equal 100% of Footnote 3(c) and 3(d).

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† Annual Statement Source

	Line of Business	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(1)	Premium	P7, C2, L1 + L2	P7, C3, L1 + L2	P7, C4 & C5, L1 + L2			P7, C10, L1 + L2	
(2)	Title XVIII-Medicare	P7, C7, L1 + L2	XXX	XXX	XXX	XXX	XXX	P7, C7, L1 + L2
(3)	Title XIX-Medicaid	P7, C8, L1 + L2	XXX	XXX	XXX	XXX	XXX	P7, C8, L1 + L2
(4)	Other Health Risk Revenue	P7, C6, L4	XXX	P7, C4 & C5, L4			XXX	
(6)	Net Incurred Claims	P7, C2+C7+C8, L1	P7, C3, L17	P7, C4 & C5, L17			XXX	
(7)	Fee-For-Service Offset	P7, C2, L3	XXX	P7, C4 & C5 , L3			XXX	
(14)	Maximum Per-Individual Risk After Reinsurance	Gen Int Pt 2 5.31 + 5.32	Gen Int Pt 2 5.33	Gen Int Pt 2 5.34			XXX	XXX

Denotes items that must be manually entered on filing software.

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† **Annual Statement Source**

	Line of Business	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
(4)	Premium	P7, C2, L1 + L2	P7, C3, L1 + L2	P7, C4 & C5, L1 + L2			P7, C10, L1 + L2	0
(5)	Title XVIII-Medicare	P7, C7, L1 + L2	XXX	XXX	XXX	XXX	XXX	P7, C7, L1 + L2
(6)	Title XIX-Medicaid	P7, C8, L1 + L2	XXX	XXX	XXX	XXX	XXX	P7, C8, L1 + L2
(7)	Other Health Risk Revenue	P7, C2, L4	XXX	P7, C4 & C5, L4			XXX	0
(12)	Title XVIII-Medicare Net Incurred Claims	P7, C7, L17	XXX			XXX	XXX	0
(13)	Title XIX-Medicaid Net Incurred Claims	P7, C8, L17	XXX			XXX	XXX	0
(15)	Net Incurred Claims	P7, C2 + C7 + C8, L17	P7, C3, L17	P7, C4 & C5, L17			XXX	0
(16)	Fee-For-Service Offset	P7, C5, L3	XXX	P7, C4 & C5 L3			XXX	0
(29)	Maximum Per-Individual Risk After Reinsurance	Gen Int Pt 2 5.31+ 5.32	Gen Int Pt 2 L33	Gen Int Pt 2, L5.34			XXX	XXX

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		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Underwriting Risk					
(19)	Business with Rate Guarante[illegible]etween 15-36 Months - Direct Premium Earned	Gen Int Pt 2 9.21		0.024	
(20)	Business with Rate Guara[illegible]ees over 36 Months - Direct Premium Earned	Gen Int Pt 2 9.22		0.064	
(21)	FEHBP and TRICARE [illegible]laims incurred	UI, Pt 2, Col 6, Line 12.4		0.020	
(22)	Stop Loss and Minimum Prem[illegible]m	Company Records		*	
(22.1)	Supplemental Benefits within [illegible]d-A[illegible]Medicare Part D Coverage **(Claims Incurred)**	Company Records		**0.500**	
(22.2)	Total Other Underwriting Risk	Sum of lines (19) through (22.1)			
Disability Income Premium					
(23)	Noncancellable Disability Income - Individual Morbidity	Company Records			
(23.1)	First $50 Million Earned Premium of L(23)			0.350	
(23.2)	Over $50 Million Earned Premium of L(23)			0.150	
(23.3)	Total Noncancellable Disability Income - Individual Morbidity	L(23.1) + L(23.2)			
(24)	Other Disability Income - Individual Morbidity	Company Records			
(24.1)	Earned Premium in L(24) [up to $50 million less Premium in L(23.3)]			0.250	
(24.2)	Earned Premium in L(24) not included in L(24.1)			0.070	
(24.3)	Total Other Disability Income - Individual Morbidity	L(24.1) + L(24.2)			
(25)	Disability Income - Credit Monthly Balance Plans	Company Records			
(25.1)	First $50 Million Earned Premium of L(25)			0.200	
(25.2)	Over $50 Million Earned Premium of L(25)			0.030	
(25.3)	Total Disability Income - Credit Morbidity	L(25.1) + L(25.2)			
(26)	Disability Income - Group Long-term	Company Records			
(26.1)	Earned Premium in L(26) [up to $50 million less Premium in L(25.1)]			0.150	
(26.2)	Earned Premium in L(26) not included in L(26.1)			0.030	
(26.3)	Total Disability Income - Group Long-term	L(26.1) + L(26.2)			
(27)	Disability Income - Credit Single Premium with Additional Reserves	Company Records			
(27.1)	Additional Reserves for Credit Disability Plans	Company Records			
(27.2)	Additional Reserves for Credit Disability Plans, prior year	Company Records			
(27.3)	Sub-total Disability Income - Credit Single Prem w/Addl Reserves	L(27) - L(27.1) + L(27.2)			
(27.4)	Earned Premium in L(27.3) [up to $50 million less Premium in lines (25.1)+(26.1)]			0.100	
(27.5)	Earned Premium in L(27.3) not included in L(27.4)			0.030	
(27.6)	Total Disability Income - Credit Single Premium with Additional Reserves	L(27.4) + L(27.5)			
(28)	Disability Income - Credit Single Premium without Additional Reserves	Company Records			
(28.1)	Earned Prem in L(28) [up to $50 million less Prem in Lines (25.1)+(26.1)+(27.4)]			0.150	
(28.2)	Earned Premium in L(28) not included in L(28.1)			0.030	
(28.3)	Total Disability Income - Credit Single Premium without Additional Reserves	L(28.1) + L(28.2)			
(29)	Disability Income - Group Short-term	Company Records			
(29.1)	Earned Prem in L(29) [up to $50 million less Prem in lines (25.1)+(26.1)+(27.4)+(28.1)]			0.050	
(29.2)	Earned Premium in L(29) not included in L(29.1)			0.030	
(29.3)	Total Disability Income - Group Short-term	L(29.1) + L(29.2)			

Denotes items that must be manually entered on filing software.

*** A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (22) and a factor of .250 will be applied to the remiaining premium in excess of $25,000,000.**

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Long-Term Care (LTC) Insurance Premium		Annual Statement Source	(1) Amount	Factor		(2) RBC Requirement
(30)	Noncancellable LTC Premium - Rate Risk	Company Records		0.100	*	
(31)	All LTC Premium - Morbidity Risk (to $50 million)	Line (34.1) Column (1) up to $50 million		0.100		
(32)	LTC Premium (over $50 million) - Morbidity Risk	Remainder of Line (34.1) Column (1) over $50 million		0.030		
(33)	Premium-based RBC	Col (2), Line (30) + Line (31) + Line (32)				

Historical Loss Ratio Experience		Annual Statement Source	(1) Premiums	(2) Incurred Claims	(3) Col. (2)/(1) Loss Ratio	§	(4) RBC Requirement
(34.1)	Current Year	Company Records					
(34.2)	Immediate Prior Year	Company Records					
(34.3)	Average Loss Ratio	If loss ratios are used, [Column (3), Line (34.1) + Line (34.2)]/2, otherwise zero]					
(35)	Adjusted LTC Claims for RBC	If Column (3) Line (34.3) <> 0 then [Column (1), Line (31) + Line (32)] x Column (3) Line (34.3), else Column (2) Line (34.1)					
(35.1)	Claims (to $35 million) - Morbidity Risk	Lower of Col.(2), Line (35) and $35 million			0.370	†	
(35.2)	Claims (over $35 million) - Morbidity Risk	Excess of Col. (2), Line (35) over $35 million			0.120	‡	
(36)	LTC Claims Reserves	Company Records			0.050		
(37)	Claims-based RBC	Col. (4), L (35.1) + L (35.2)					
(38)	LTC RBC	Col. (2), L (33) + Col. (4), L (36) + L(37)					

* The factor applies to all Noncanellable premium.

† If Column (1), Line (34.1) is positive, then a factor of 0.250 is used. Otherwise, a higher factor of 0.370 is used

‡ If Column (1), Line (34.1) is positive, then a factor of 0.080 is used. Otherwise, a higher factor of 0.120 is used

§ If Column (1), Line (34.1) or (34.2) are less than or equal to zero or if Column (2), Line (34.1) or (34.2) are less than zero, the loss ratios are not used and Column (3), Line (34.3) is set to zero.

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Limited Benefit Plans (Individual and Group Combined)		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
(39)	Hospital Indemnity and Specified Disease	Included in Page 7, Col 9, Line 1 and 2, in part		0.035	
(39.1)	50,000 if L(39) is greater than zero				
(39.2)	Total Hospital Indemnity and Specified Disease	L(39) + L (39.1)			
(40)	Accidental Death & Dismemberment	Included in Page 7, Col 9, Line 1 and 2, in part			
(40.1)	First 10 Million Earned Premium of L(40)			0.055	
(40.2)	Over 10 Million Earned Premium of L (40)			0.015	
(40.3)	Maximum Retained Risk for any single claim	Company Records			
(40.4)	Three times L (40.3)				
(40.5)	Lesser of L (40.4) or $300,000				
(40.6)	Total AD&D	L(40.1) + L(40.2) + L(40.5)			
(41)	Other Accident	Included in Page 7, Col 9, Line 1 and 2, in part		0.050	
(42)	Premium Stabilization Reserves	Included in U&I, Part 2D, Col 1, Line 4		-0.500 Φ	
(43)	Total Other Underwriting Risk	L(22.2)+L(23.3)+L(24.3)+L(25.3)+ L(26.3)+L(27.6)+L(28.3)+L(29.3)+L(39.2)+L(40.6)+L(41)+L(42)			

Φ This is limited to the total Net Underwriting RBC on XR012, Col (7), Line (18) Less Col (4), and XR014, Col (2), Lines (22.2), (23.3),(24.3),(25.3), (26.3),(27.6),(28.3),(29.3), XR015 Col (2), Line (33) and XR016 Col (2), Lines (39.2), (40.6), and (41).

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UNDERWRITING RISK - Managed Care Credit Calculation

			(1)	(2)	(3)	(4)
	Managed Care Claims Payments	**Annual Statement Source**	Factor	Paid Claims	Weighted Claims†	Part D Weighted Claims‡
(1)	Category 0 - Arrangements Not Included in Other Categories	Exhibit 7, Pt 1, Col 1, Line 5, in part §	0			
(2)	Category 1 - Payments Made According to Contractual Arrangements	Exhibit 7, Pt 1, Col 1, Line 6, in part §	0.150			
(3)	Category 2a - Subject to Withholds or Bonuses - Otherwise Category 0	Exhibit 7, Pt 1, Col 1, Line 7, in part §	*			
(4)	Category 2b - Subject to Withholds or Bonuses - Otherwise Category 1	Exhibit 7, Pt 1, Col 1, Line 8, in part §	*			
(5)	Category 3a - Capitated Payments Directly to Providers		0.600			
(5.1)	Capitation Payments - Medical Group - Category 3a	Exhibit 7, Pt 1, Col 1, Line 1, in part §				
(5.2)	Capitation Payments - All Other Providers - Category 3a	Exhibit 7, Pt 1, Col 1, Line 3, in part §				
(6)	Category 3b - Capitated Payments to Regulated Intermediaries	Included in Exhibit 7, Pt 1, Col 1, Line 2 §	0.600			
(7)	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Included in Exhibit 7, Pt 1, Col 1, Line 2 §	0.600			
(8)	Category 4 - Medical & Hospital Expense Paid as Salary to Providers		0.750			
(8.1)	Non-contingent Salaries - Category 4	Exhibit 7, Pt 1, Col 1, Line 9, in part §				
(8.2)	Aggregate Cost Arrangements - Category 4	Exhibit 7, Pt 1, Col 1, Line 10, in part §				
(8.3)	Less Fee For Service revenue from ASC or ASO	Company Records				
(9)	Sub-Total Paid Claims	Exhibit 7, Pt 1, Col 1, Line 13 - Line 11 - Line (8.3) - Line (12) - Line (13)				
	Stand-Alone Medicare Part D Coverage Claim Payments					
(10)	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company Records	xxx	xxx		xxx
(11)	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company Records	xxx	xxx		xxx
(12)	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company Records	.667			
(13)	Category 3a - Federal Reinsurance and Risk Corridor Protection Apply	Company Records	.767			
(14)	Sub-Total Paid Claims	Sum of Lines (10) through (13)				
(15)	Total Paid Claims	Sum of Lines (9) and (14)				
(16)	Weighted Average Managed Care Discount					
(17)	Weighted Average Managed Care Risk Adjustment Factor					

† This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.
‡ This column is for the Medicare Part D managed care discount factor.
§ Stand-alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.
* The factor is calculated on page XR018.
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		Annual Statement Source	(1) Amount
*** Calculation of Category 2 Managed Care Factor**			
(18)	Withhold & Bonus Payments, ***Prior Year***	Company Records	
(19)	Withhold & Bonuses Available, ***Prior Year***	Company Records	
(20)	MCC Multiplier - Average Withhold Returned [L(18)/L(19)]		
(21)	Withholds & Bonuses Available, ***Prior Year***	Company Records	
(22)	Claims Payments Subject to Withhold, ***Prior Year***	Company Records	
(23)	Average Withhold Rate, Prior Year [L(21)/L(22)]		
(24)	MCC Discount Factor, Category 2 - Min{.25,[L(20) x L(23)]}		

* The factor is pulled into Lines (3) and (4) on page XR017.

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CREDIT RISK

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Reinsurance Ceded					
(1)	Recoverables on Paid Losses - 100% Owned Affiliates	Included in Sch S, Pt 2, Col 6, Line 1899999			
(2)	Recoverables on Paid Losses - Other Affiliates	Included in Sch S, Pt 2, Col 6, Line 1899999		0.005	
(3)	Recoverables on Paid Losses - Non-Affiliates (Excluding ACA Reinsurance)	Included in Sch S, Pt 2, Col 6, Line 2199999			
(4)	Recoverables on Paid Losses - Affordable Care Act	Notes to Financial Statement 24E(2)b1			
(5)	Recoverables on Paid Losses - Non-Affiliates	Lines (3) + (4)		0.005	
(6)	Total Recoverables on Paid Losses	Lines (1) + (2) + (5) (Sch S, Pt 2, Col 6, Line 2299999)			
(7)	Recoverables on Unpaid Losses - 100% Owned Affiliates	Included in Sch S, Pt 2, Col 7, Line 1899999			
(8)	Recoverables on Unpaid Losses - Other Affiliates	Included in Sch S, Pt 2, Col 7, Line 1899999		0.005	
(9)	Recoverables on Unpaid Losses - Non-Affiliates (Excluding ACA Reinsurance)	Included in Sch S, Pt 2, Col 7, Line 2199999			
(10)	Recoverables on Unpaid Losses - Affordable Care Act	Notes to Financial Statement 24E(2)b2			
(11)	Recoverables on Unpaid Losses - Non-Affiliates	Lines (9) + (10)		0.005	
(12)	Total Recoverables on Unpaid Losses	Lines (7) + (8) + (11) (Sch S, Pt 2, Col 7, Line 2299999)			
(13)	Unearned Premiums - 100% Owned Affiliates	Included in Sch S, Pt 3, Sn 2, Col 9, Line 0799999 + Line 1899999+Line 2999999			
(14)	Unearned Premiums - Other Affiliates	Included in Sch S, Pt 3, Sn 2, Col 9, Line 0799999 + Line 1899999 + Line 2999999		0.005	
(15)	Unearned Premiums - Non-Affiliates	Included in Sch S, Pt 3, Sn 2, Col 9, Line 1099999 + Line 2199999 + Line 3299999		0.005	
(16)	Total Unearned Premiums	Lines (13) + (14) + (15)			
(17)	Other Reserve Credits - 100% Owned Affiliates	Included in Sch S, Pt 3, Sn 2, Col 10, Line 0799999 + Line 1899999 + Line 2999999			
(18)	Other Reserve Credits - Other Affiliates	Included in Sch S, Pt 3, Sn 2, Col 10, Line 0799999 + Line 1899999 + Line 2999999		0.005	
(19)	Other Reserve Credits - Non-Affiliates	Included in Sch S, Pt 3, Sn 2, Col 10, Line 1099999 + Line 2199999 + Line 3299999		0.005	
(20)	Total Other Reserve Credits	Lines (17) + (18) + (19)			
(21)	Total Reinsurance RBC	L(6)+L(12)+L(16)+L(20)			
Capitations to Intermediaries					
(22)	Total Capitations Paid Directly to Providers	XR017, Col (2), Line (5)			
(23)	Less Secured Capitations to Providers	Company Records			
(24)	Capitation to Providers Subject to Credit Risk Charge	L(22)-L(23)		0.020	
(25)	Total Capitations to Intermediaries	XR017, Col (2), Line (6)+(7)			
(26)	Less Secured Capitations to Intermediaries	Company Records			
(27)	Capitations to Intermediaries Subject to Credit Risk Charge	L(25)-L(26)		0.040	
(28)	Capitation Credit Risk RBC	L(24)+L(27)			

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		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Receivables					
(29)	Investment Income Receivable	Page 2, Col 3, Line 14		0.010	
(30)	Health Care Receivables	Exhibit 3, Col 7, Line 0799999			
(30.1)	Pharmaceutical Rebate Receivables	Exhibit 3, Col 7, Line 0199999		0.050	
(30.2)	Claim Overpayment Receivables	Exhibit 3, Col 7, Line 0299999		0.190	
(30.3)	Loan and Advances to Providers	Exhibit 3, Col 7, Line 0399999		0.190	
(30.4)	Capitation Arrangement Receivables	Exhibit 3, Col 7, Line 0499999		0.190	
(30.5)	Risk Sharing Receivables	Exhibit 3, Col 7, Line 0599999		0.190	
(30.6)	Other Heath Care Receivables	Exhibit 3, Col 7, Line 0699999		0.190	
(31)	Amounts Receivable Relating to Uninsured Accident and Health Plans	Included in Page 2, Col 3, Line 17		0.050	
(32)	Amounts Due from Parents, Subs, and Affiliates	Page 2, Col 3, Line 23		0.050	
(33)	Aggregate Write-ins For Other Than Invested Assets	Page 2, Col 3, Line 25		0.050	
(34)	Total Other Receivables RBC	L(29) + Sum L(30.1) through L(33)			
(35)	Total Credit RBC	L(21)+L(28)+L(34)			

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BUSINESS RISK

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Administrative Expense R					
(1)	Claims Adjustment Expenses	Page 4, Col 2, Line 20			
(2)	General Administrative Expenses	Page 4, Col 2, Line 21			
(3)	less the Net Amount of ASC Revenue and Expenses included in Line 1 and 2	Company Records			
(4)	less the Net amount of ASO Revenue and Expenses Included in Line 1 and 2	Company Records			
(5)	less Admin Expenses for Commissions, Premium Taxes	Underwriting & Investment Exhibit Part 3, Line 3, in part			
(6)	Administrative Expense Base RBC	L(1)+L(2)-L(3)-L(4)-L(5)		*	
(7)	Proration of Admin Expense to Experience Fluctuation Risk	L(6) x L(20)/(L(21)+L(22))			
Non-Underwritten and Limited-Risk					
(8)	Administrative Expenses for ASC Arrangements	Company Records		0.020	
(9)	Administrative Expenses for ASO Arrangements	Company Records		0.020	
(10)	Medical Costs Paid Through ASC Arrangements (Including Fee-for Service Received From Other Health Entities)	Company Records		0.010	
(11)	Non-Underwritten and Limited Risk Business RBC				
Guaranty Fund Assessment Risk					
(12)	Premiums Subject to Guaranty Fund Assessment	Included in Sch T Company Records		0.005	
Excessive Growth Risk					
(13)	UW Risk Revenue, Prior Year	**2016** XR012, Col (7), Line (5) *(manual entry)* †			
(14)	UW Risk Revenue, Current Year	**2017** XR012, Col (7), Line (5)			
(15)	Net UW Risk RBC, Prior Year	**2016** XR012, Col (7), Line (18) *(manual entry)* †			
(16)	Net UW Risk RBC, Current Year	**2017** XR012, Col (7), Line (18)			
(17)	RBC Growth Safe Harbor	[L(14)/L(13)+.10] x L(15)			
(18)	Excess of RBC Growth Over Safe Harbor	Max{0,L(16) - L(17)}			
(19)	Excessive Growth Risk RBC	.5 x L(18)			
			Premium	Weight	Weighted Premium
(20)	Experience Fluctuation Risk Revenue	XR012, Col (7), Line (5)			
(21)	Premiums Earned	Page 4, Col 2, Line 2 + 3			
(22)	Risk Revenue	Page 4, Col 2, Line 5			
(23)	Tier 1 - $0 to $25 million of Line (20)			0.070	
(24)	Tier 2 - Amount over $25 million of Line (20)			0.040	
(25)	Total Experience Fluctuation Risk Revenue	L(23)+L(24)			
(26)	Administrative Expenses Base RBC Factor	Col (2), Line (25) / Col (1), Line (25)			

'* The factor for the Administrative Expenses Base RBC is calculated as a weighted average, based on premium volume from XR012.

† For start-up health companies using projected amounts from the domicile state approved proforma, complete Footnote 1

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Footnote 1: If your company is a start-up health company that has received approval from your domiciliary state to use projected amounts in L(13) and L(15), please explain the projections used.

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Growth Operational Risk
(FOR INFORMATIONAL PURPOSES ONLY)

		Reference	(1) Statement Value	Factor	(2) RBC Requirement
(1)	Current Year Direct Premiums Written	U&I, Pt 1, Premiums, C1, L12			
(2)	Current Year Reinsurance Assumed from Affiliates	Sch. S, Pt 1, Sn 2, C7, L0799999 + Life Supp. Sch. S, Pt. 1, Sn. 1, C9, L0799999			
(3)	Current Year Reinsurance Assumed from Non-Affiliates	Sch. S, Pt 1, Sn 2, C7, L1099999 + Life Supp. Sch. S, Pt. 1, Sn. 1, C9, L1099999			
(4)	Current Year Gross Premiums Written Excluding Reinsurance Assumed from Affiliates	C(1), **L(1) + (3)**			
(5)	Prior Year Direct Premiums Written	PY U&I, Pt 1, Premiums, C1, L12			
(6)	Prior Year Reinsurance Assumed from Affiliates	PY Sch. S, Pt 1, Sn 2, C7, L0799999 + PY Life Supp. Sch. S, Pt. 1, Sn. 1, C9, L0799999			
(7)	Prior Year Reinsurance Assumed from Non-Affiliates	PY Sch. S, Pt 1, Sn 2, C7, L1099999 + PY Life Supp. Sch. S, Pt. 1, Sn. 1, C9, L1099999			
(8)	Prior Year Gross Premiums Written Excluding Reinsurance Assumed from Affiliates	C(1), **L(5) + (7)**			
(9)	Gross Written Premium in Excess of 125% of Prior Year's Gross Written Premium	C(1), **L(4)** - 1.25 x C(1), **L(8)**		0.0200	

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FEDERAL ACA RISK ADJUSTMENT AND RISK CORRIDOR SENSITIVITY TEST:

		Annual Statement Source	(1) Amount	Sensitivity Percentage	(2) Subtotal Col. (1) * Col. (2)	Factor	(3) RBC Result	(4) Adjusted Capital
	Overestimation of 25%							
(1)	Premium Adjustments Receivable Due to ACA Risk Adjustment	Notes to Financial Statement 24E2a1		0.75		0.500		
(2)	Premium Adjustments Payable Due to ACA Risk Adjustment	Notes to Financial Statement 24E2a3		0.75		0.500		
(3)	Total ACA Risk Adjustments Payable less Receivable	Line (2) - Line (1)						
(4)	Accrued Retrospective Premium Due to ACA Risk Corridors	Notes to Financial Statement 24E2c1		0.75		0.500		
(5)	Reserve for Rate Credits or Policy Experience Rating Refunds Due to ACA Risk Corridors	Notes to Financial Statement 24E2c2		0.75		0.500		
(6)	Total ACA Risk Corridor Retrospective Premium and Rate Credits or Policy Experience Rating Refunds (Net)	Line (5) - Line (4)						
(7)	Total Risk Adjustment and Risk Corridor	Absolute Value of (Line (3) + Line (6))						
(8)	Total Adjusted Capital, Post-deferred Tax	XR026, Col. (2), Line (6)						
(9)	Total Adjusted Capital Stressed for Risk Adjustments	Line (8) - Line (7)						
(10)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)						
(11)	ACA Risk Adjusted ACL RBC Ratio	Line (9)/Line (10)						
	Underestimation of 25%							
(12)	Premium Adjustments Receivable Due to ACA Risk Adjustment	Col. (1), Line (1)		1.25		0.500		
(13)	Premium Adjustments Payable Due to ACA Risk Adjustment	Col. (1), Line (2)		1.25		0.500		
(14)	Total ACA Risk Adjustments Payable less Receivable	Line (13) - Line (12)						
(15)	Accrued Retrospective Premium Due to ACA Risk Corridors	Col. (1), Line (4)		1.25		0.500		
(16)	Reserve for Rate Credits or Policy Experience Rating Refunds Due to ACA Risk Corridors	Col. (1), Line (5)		1.25		0.500		
(17)	Total ACA Risk Corridor Retrospective Premium and Rate Credits or Policy Experience Rating Refunds (Net)	Line (16) - Line (15)						
(18)	Total Risk Adjustment and Risk Corridor	Absolute Value of (Line (14) + Line (17))						
(19)	Total Adjusted Capital, Post-deferred Tax	XR026, Col. (2), Line (6)						
(20)	Total Adjusted Capital Stressed for Risk Adjustments	Line (19) - Line (18)						
(21)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)						
(22)	ACA Risk Adjusted ACL RBC Ratio	Line (20)/Line (21)						

Footnote: If it is the belief of the company that the factors are not appropriate, provide an explanation as to why the factors are inappropriate. _____

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CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

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			(1) RBC Amount
H0 - ASSET RISK - AFFILIATES W/RBC			
(1)	Off-Balance Sheet Items	XR005, Off-Balance Sheet Page, L(21)	
(2)	Directly Owned Insurer Subject to RBC	XR003, Affiliates Page, L(1)	
(3)	Indirectly Owned Insurer Subject to RBC	XR003, Affiliates Page, L(2)	
(4)	Directly Owned Health Entity Subject to RBC	XR003, Affiliates Page, L(3)	
(5)	Indirectly Owned Health Entity Subject to RBC	XR003, Affiliates Page, L(4)	
(6)	Directly Owned Alien Insurer	XR003, Affiliates Page, L(7)	
(7)	Indirectly Owned Alien Insurers	XR003, Affiliates Page, L(8)	
(8)	Total H0	Sum L(1) through L(7)	
H1 - ASSET RISK - OTHER			
(9)	Investment Affiliates	XR003, Affiliates Page, L(5)	
(10)	Holding Company Excess of Subsidiaries	XR003, Affiliates Page, L(6)	
(11)	Investment in Parent	XR003, Affiliates Page, L(9)	
(12)	Other Affiliates	XR003, Affiliates Page, L(10)	
(13)	Fair Value Excess Affiliate Common Stock	XR003, Affiliates Page, L(11)	
(14)	Fixed Income Assets	XR006, Off-Balance Sheet Collateral, L(9) + L(19) + L(20) + L(21) + XR007, Fixed Income Assets Page, **L(33)**	
(15)	Replication & Mandatory Convertible Securities	XR008, Replication/MCS Page, L(9999999)	
(16)	Unaffiliated Preferred Stock and Hybrid Securities	XR006, Off-Balance Sheet Collateral, L(16) + XR009, Equity Assets Page, L(15)	
(17)	Unaffiliated Common Stock	XR006, Off-Balance Sheet Collateral, L(17) +XR009, Equity Assets Page, L(21)	
(18)	Property & Equipment	XR006, Off-Balance Sheet Collateral, L(18) + XR010, Prop/Equip Assets Page, L(9)	
(19)	Asset Concentration	XR011, Grand Total Asset Concentration Page, L(23)	
(20)	Total H1	Sum L(9) through L(19)	
H2 - UNDERWRITING RISK			
(21)	Net Underwriting Risk	XR012, Underwriting Risk Page, L(18)	
(22)	Other Underwriting Risk	XR014, Underwriting Risk Page, L(22.2)	
(23)	Disability Income	XR014, Underwriting Risk Page, L(23.3)+L(24.3)+L(25.3)+(26.3)+(27.6)+(28.3)+(29.3)	
(24)	Long-Term Care	XR015, Underwriting Risk Page, L(38)	
(25)	Limited Benefit Plans	XR016, Underwriting Risk Page, L(39.2)+L(40.6)+L(41)	
(26)	Premium Stabilization Reserve	XR016, Underwriting Risk Page, L(42)	
(27)	Total H2	Sum L(21) through L(26)	

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CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

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			(1) RBC Amount
H3 - CREDIT RISK			
(28)	Total Reinsurance RBC	XR019, Credit Risk Page, L(21)	
(29)	Intermediaries Credit Risk RBC	XR019, Credit Risk Page, L(28)	
(30)	Total Other Receivables RBC	XR020, Credit Risk Page, L(34)	
(31)	Total H3	Sum L(28) through L(30)	
H4 - BUSINESS RISK			
(32)	Administrative Expense RBC	XR021, Business Risk Page, L(7)	
(33)	Non-Underwritten and Limited Risk Business RBC	XR021, Business Risk Page, L(11)	
(34)	Premiums Subject to Guaranty Fund Assessments	XR021, Business Risk Page, L(12)	
(35)	Excessive Growth RBC	XR021, Business Risk Page, L(19)	
(36)	Total H4	Sum L(32) through L(35)	
(37)	RBC after Covariance **Before Basic Operational Risk**	L() + Square Root of ($H1^2$+$H2^2$+$H3^2$+$H4^2$)	
(38)	**Basic Operational Risk**	**0.0 x L(37)**	
(39)	**RBC After Covariance Including Basic Operational Risk**	**L(37) + L(38)**	
(40)	Authorized Control Level RBC	**.50 x L(39)**	

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CALCULATION OF TOTAL ADJUSTED CAPITAL

		Annual Statement Source	(1) Amount	Factor	(2) Adjusted Capital
Company Amounts					
(1)	Capital and Surplus	Page 3, Col 3, Line 33	$0	1.000	
Subsidiary Adjustments					
(2)	AVR - Life Subsidiaries	Affiliate's statement §		1.000	
(3)	Dividend Liability - Life Subsidiaries	Affiliate's statement		0.500	
(4)	Tabular Discounts - P&C Subsidiaries	Affiliate's statement		-1.000	
(5)	Non-Tabular Discounts - P&C Subsidiaries	Affiliate's statement		-1.000	
(6)	Total Adjusted Capital, Post-deferred Tax				
Sensitivity Test:					
(7)	DTA Value for Company	Page 2, Col 3, Line 18.2		1.000	
(8)	DTL Value for Company	Page 3, Col 3, Line 10.2		1.000	
(9)	DTA Value for Insurance Subsidiaries	Company Records		1.000	
(10)	DTL Value for Insurance Subsidiaries	Company Records		1.000	
(11)	Total Adjusted Capital, Pre-deferred Tax (sensitivity)	L(6) + L(7) + L(8) + L(9) + L(10)			
Ex DTA ACL RBC Ratio Sensitivity Test					
(12)	Deferred Tax Asset	Page 2 Column 3 Line 18.2		1.000	
(13)	Total Adjusted Capital Less Deferred Tax Asset	Line (6) less Line (12)			
(14)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			
(15)	Ex DTA ACL RBC Ratio	Line (13) / Line (14)			0.000%
ACA Fee RBC Ratio Sensitivity Test					
(16)	ACA Fee (Data Year Amount to be Paid in the Fee Year)	Note 22B		1.000	$0
(17)	Total Adjusted Capital Less ACA Fee	Line (6) less Line (16)			$0
(18)	Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			$0
(19)	ACA Fee RBC Ratio	Line (17) / Line (18)			0.000%

§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

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COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount	(2) Result
(1)	Total Adjusted Capital Post-Tax			
(2)	Company Action Level=200% of Authorized Control Level	CAL		
(3)	Regulatory Action Level=150% of Authorized Control Level	RAL		
(4)	Authorized Control Level=100% of Authorized Control Level	ACL		
(5)	Mandatory Control Level=70% of Authorized Control Level	MCL		
(6)	Level of Action, if Any			

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE-YEAR HISTORY ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page	
Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page	

TREND TEST

		Annual Statement Source		
(7)	Total Revenue	Page 4, Line 8		
(8)	Underwriting Deductions	Page 4, Line 23		
(9)	Combined Ratio	Line (8)/Line (7)	0.000%	
(10)	RBC Ratio	Line(1)/Line (4)	0.000%	
(11)	Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then "Yes," otherwise "No"		
(12)	Level of Action, if any, including Trend Test			

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Health
Risk-Based Capital Forecasting
Spreadsheet Instructions

The Health RBC Forecasting CD-ROM contains a spreadsheet that calculates RBC using the same formula presented in the *2017 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies*. (A hardcopy of this booklet is mailed with the forecasting CD-ROM or is available for download from the NAIC Publications Department.)

This forecasting spreadsheet can be used to check RBC results throughout the year, to get an early look at RBC results before the RBC vendor filing software may be available, or to evaluate "what-if" scenarios.

WARNING!

The Risk-Based Capital Forecasting Spreadsheet CANNOT be used to meet the year-end risk-based capital electronic filing requirement. Risk-based capital 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.

User Requirements

- A Microsoft Windows® version of Microsoft Excel 2010 (or compatible versions).
- Four megabytes of hard disk space
- A good understanding of spreadsheet software.

Installation from the CD-ROM

To install the spreadsheet files, start Windows Explorer and go to the CD-ROM drive where the forecasting spreadsheet is located.

Copy and Paste the **Forecast_Health_2017_10_20.xlsm** file in the directory where you would like the file to be saved.

About the File

The spreadsheet **Forecast_Health_2017_10_20.xlsm** was created in Microsoft Excel. The spreadsheet can be used with Microsoft Excel version 14.0 or higher. The spreadsheet includes menus for use in navigation between pages and for printing.

The RBC spreadsheet above follows the *2017 NAIC Health Risk-Based Capital Report Including Overview and Instructions for Companies* formula pages. A copy of the instructions and blank are included with the CD-ROM to assist in the completion of the forecasting file.

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Usage

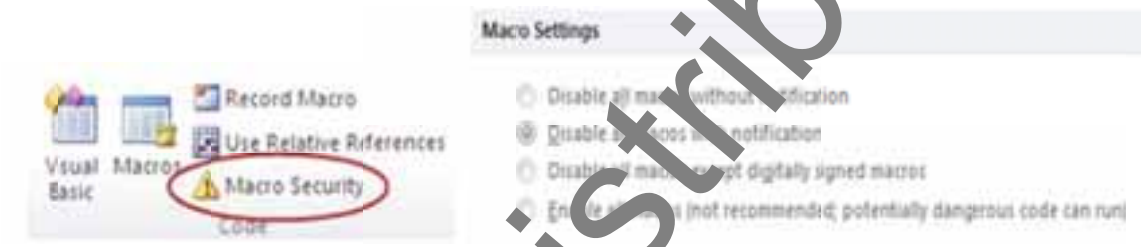
1. Open the **Forecast_Health_2017_10-20.xlsm** file by double clicking on the file.
2. Enter data as described in the following sections and examine the results.
3. Save any changes to the spreadsheets using the "Save" command from the "File" menu.

Please Note

In certain versions of Excel, the user may receive the following message when the forecasting file is opened:

If this is the case, the user would need to click on the "Enable Content" button.

To change the Excel security level, go to the Developer tab, in the Code group, click Macro Security. In the Macro Settings, select the security option.



Data Entry

The spreadsheets have been color-coded for easy use.

- Blue-shaded cells are data elements that tie directly to the 2017 health annual statement (i.e., vendor link items). This data can be found in the company annual statement filing.
- Red-shaded cells are data elements that are not available directly from the annual statement (i.e., manual data entry items). These items come from other company records as noted in the spreadsheet.
- Cells that are not shaded are data elements calculated automatically by the spreadsheet. These cells are protected.
- Green-shaded cells are data elements that must be entered using a separate input worksheet. Clicking on the cell will automatically take the user to the input worksheet. Data input into the separate worksheet will feed automatically to the main page.

What-If Scenarios

One of the unique features of the forecasting spreadsheet is its ability to perform what-if calculations. Because the formula is implemented through the Excel spreadsheet, the user is able to run various scenarios by adjusting the book/adjusted carrying value, amount or statement value to analyze the effect such changes would have on the company's overall RBC ratio based on the RBC factors and covariance.

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Saving and Exiting

To exit the program, simply click the  in the upper right corner of the file or choose the "Exit" option from the "File" menu. The spreadsheet program will prompt to save any files which have been changed.

- Answer "yes" to save any changes such as data input or formula changes.
- Answer "no" if saving is not desired. **Warning**: This will ignore any and all other changes made.

Printing

A print menu was added to the Microsoft Excel file to aid in printing. Click on each box next to the page name for the individual pages that are desired to be printed. Then select the button for "Print Selected Pages." Select the "Reset" button any time it is desired to have all buttons deselected. Individual boxes can also be deselected by clicking on them.

RBC Forecasting Tips

1. Make sure the CD-ROM is retained so a back-up copy of the Excel file is available. The NAIC will not replace the CD-ROM unless it was damaged during shipping or is otherwise defective.
2. Gather information required for the affiliated investments section before beginning. In some instances, information will need to be gathered from the various affiliates themselves.
3. Keep a copy of the NAIC annual statement blank and annual statement instructions nearby and refer to them as needed.
4. Keep the copy of the RBC Overview and Instructions at the computer to be used as a reference while filling out the spreadsheet. The spreadsheet follows the RBC Overview and Instructions formula pages exactly.
5. Make a list of questions while filling out the spreadsheet. Then call the NAIC staff once, saving both parties time.
6. When leaving voicemail messages, make the question as specific and detailed as possible. We will then be able to call back with the answer, saving time spent on the phone. Please leave a phone number or email address and we will get back with an answer as soon as possible.

Questions and Support

If problems are encountered, please refer to the Health RBC Overview & Instructions booklet and/or the Forecasting Spreadsheet Instructions. However, if there is still a question, contact the NAIC.

For questions pertaining to annual statement references, insurance accounting questions or formula questions, contact Crystal Brown.

For computer usage related questions (loading the product, etc.), contact the NAIC Help Desk.

Important Contact Information

- RBC Formula questions: Crystal Brown, (816) 783-8146 or *cbrown@naic.org*.
- Computer questions: NAIC Help Desk, (816) 783-8500 or *help@naic.org*.
- Annual statement questions: NAIC Financial Reporting Questions Help Line, (816) 783-8400.
- Questions on publications: NAIC Publications, (816) 783-8300 or *prodserv@naic.org*.

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RBC
Risk-Based Capital

2017 FORECASTING CD-ROM

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For more information, visit **www.naic.org**.

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