Capital Adequacy (E) Task Force

RBC Proposal Form

[x] Capital Adequacy (E) Task Force	[ ] Health RBC (E) Working Group	[ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup	[ ] Investment RBC (E) Working Group	[ ] SMI RBC (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup	[ ] P/C RBC (E) Working Group	[ ] Stress Testing (E) Subgroup

DATE: 5-25-2017

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FOR NAIC USE ONLY

Agenda Item # 2017-08-CA
Year 2018

DISPOSITION

[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[x] REFERRED TO OTHER NAIC GROUP
[x] EXPOSED 1-15-18
[ ] OTHER (SPECIFY)

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

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

DESCRIPTION OF CHANGE(S)

Modify the Underwriting Risk – Other page XR014 to add a new line (22.2) for Medicaid Pass-Through Payments. The Medicaid Pass-Through Payments would then be subtracted from the premium and claim amounts on pages XR012 & XR012A.

REASON OR JUSTIFICATION FOR CHANGE **

Currently, the treatment of Medicaid Pass-Through payments vary from state to state and in many cases is being treated as premium in the Underwriting Risk and receiving the full Underwriting Risk charge. These payments are more like uninsured business, such as ASO and ASC business that is included in the business risk section. ASO and ASC business receive a 2% charge. However, due to the complexity and varying treatment of these payments, the Working Group recommends adding a new line to page XR014 and apply a 2% factor to Medicaid Pass-Through Payments that are Reported as Premium. These amounts would then be subtracted from the premium and claims amounts reported on pages XR012 and XR012-A. This would address the treatment of these payments as premiums by states; however, they would have a charge similar to business risk.

The Working Group currently has guidance in place for the treatment of the Medicaid Pass-Through Payments under proposal 2015-27-H for 2017 reporting.

Additional Staff Comments:

4-9-17 cgb The WG exposed a draft copy of the page XR014 Blank proposal until 5-9-17.
5-25-17 cgb The WG previously considered and withdrew proposal 2015-26-H for Medicaid Pass-Through Payments on 6/22/2016 based on comments received from industry on 6-9-16 indicating concerns that would result inaccurate reporting. The WG agreed to use the guidance adopted under proposal 2015-27-H for 2016 reporting and will continue to discuss how proceed on this proposal on future calls.
5-25-17 cgb No comments were received on the page XR014 draft blank exposure.
5-30-17 cgb The WG exposed the proposal for a 45 day comment period ending on 7-14-17.

8-7-17 cgb The WG received no comments on the proposal and agreed to refer the proposal up to the Capital Adequacy Task Force for consideration. The proposal number will be amended to 2017-08-CA to include blanks and instruction changes for the P/C and Life formulas as well.
11-14-17 cgb The Capital Adequacy (E) Task Force exposed the proposal for a 60 day comment period ending Jan. 15, 2018.

**** This section must be completed on all forms.** **Revised 11-2013**

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 ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at $750,000 per individual and $1,500,000 total for medical coverage; $25,000 per individual and $50,000 total for all other coverage except Medicare Part D coverage and $25,000 per individual and $150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive 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.

L(1) through L(2118)

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. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 22.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed $1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

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

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.

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

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

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

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

Line (5) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

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

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

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

Line (107) 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 (118) Underwriting Risk Incurred Claims. Line (96) minus Line (710).

Line (912) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (811) / Line (56). If either Line (56) or Line (811) is zero or negative, Line (912) is zero.

Line (130) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (65), 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 (141) Base Underwriting Risk RBC. Line (56) x Line (912) x Line (103).

Line (125) 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 (136) RBC After Managed Care Discount. Line (114) x Line (125).

Line (174) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

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

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

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

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

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

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

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

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

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

Line (185) Alternate Risk Charge**.** This is twice the amount in Line (174) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (147), 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 (169) Alternate Risk Adjustment**.** This line shows the largest value in Line (185) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (2017) Net Alternate Risk Charge**.** This is the amount in Line (158), less the amount in the previous column of Line (196), but not less than zero. Column (6) is excluded from this calculation.

Line (2118) Net Underwriting Risk RBC**.** This is the maximum of Line (136) and Line (2017) for each of columns (1) through (5). This is the amount in Line (141), 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. 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 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 (165) 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 (156) 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(363)

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. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category. 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), (109) through (112) and (145) and (2118) through (203) 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 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.

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

Line (~~9~~8) Underwriting Risk Revenue. The sum of Lines (4) through (7) minus Line (8)~~.~~

Line (~~10~~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 (1~~1~~0) 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 (1~~2~~1) 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 (132) Title XVIII-Medicare Net Incurred Claims. Claims incurred for Medicare Risk Coverage during the reporting year (net of reinsurance) during the reporting year.

Line (143) Title XIX-Medicaid Net Incurred Claims. Claims incurred for Medicaid Risk Coverage during the reporting year (net of reinsurance) during the reporting year.

Line (154) 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.

Line (156) 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 (156) should also equal the sum of Lines (910) through (145).

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

Line (18) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims. Line (16) minus Line (17).

Line (196) 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 (2017) Underwriting Risk Incurred Claims. Line (158) minus Line (196).

Line (1821) Individual Underwriting Risk Claims Ratio. Line (109) / Line (1). If either Line (1) or Line (109) is zero or negative, Line (2118) is zero.

Line (2219) Small Group Underwriting Risk Claims Ratio. Line (101) / Line (2). If either Line (2) or Line (110) is zero or negative, Line (2219) is zero.

Line (203) Large Group Underwriting Risk Claims Ratio. Line (121) / Line (3). If either Line (112) or Line (3) is zero or negative, Line (230) is zero.

Line (241) Title XVIII-Medicare Underwriting Risk Claims Ratio. Line (132) / Line (5). If either Line (132) or Line (5) is zero or negative, Line (214) is zero.

Line (252) Title XIX-Medicaid Underwriting Risk Claims Ratio. Line (143) / Line (6). If either Line (143) or Line (6) is zero or negative, Line (252) is zero.

Line (236) Other Health Underwriting Risk Claims Ratio. Line (145) / Line (7). If either Line (145) or Line (7) is zero or negative, Line (236) is zero.

Line (274) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (2017) / Line (89). If either Line (2017) or Line (89) is zero or negative, Line (274) is zero.

Line (285) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (89), 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 (296) Base Underwriting Risk RBC. Line (89) x Line (274) x Line (258).

Line (3027) 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 (3128) RBC After Managed Care Discount. Line (269) x Line (2730).

Line (3229) 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:

1.* 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.

~~2.~~* Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to $750,000 less retention).

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

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

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

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

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

Line (3~~0~~3) Alternate Risk Charge**.** This is twice the amount in Line (32~~29~~) for Columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (32~~29~~), 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 (3~~4~~1) Alternate Risk Adjustment**.** This line shows the largest value in Line (3~~0~~) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (3~~5~~2) Net Alternate Risk Charge**.** This is the amount in Line (3~~0~~), less the amount in the previous column of Line (3~~4~~1), but not less than zero. Column (6) is excluded from this calculation.

Line (3~~6~~3) Net Underwriting Risk RBC**.** This is the maximum of Line (31~~28~~) and Line (3~~5~~2) for each of Columns (1) through (5). This is the amount in Line (2~~9~~6), 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 (165) into Lines (1) through (3) and (109) through (124), describe the basis of the allocation. Describe the basis the company used to allocate the values in Lines (4) and (156) 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 (156) 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 (109), 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.

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 guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e., Comprehensive 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.

Line (22.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital Working Group however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2 percent factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR012, Column (1), Line (5).

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.

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.

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)	**Medicaid Pass-Through Payments Reported as**		**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	
(6)	Underwriting Risk Revenue = L(1)+L(2)+L(3)+L(4)-**L(5)**							
(7) †	Net Incurred Claims		$0				XXX	
(8)	**Medicaid Pass-Through Payments Reported as Claims**		**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	
(9)	**Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = L(7)-L(8)**							
(10) †	Fee-For-Service Offset		XXX				XXX	
(11)	Underwriting Risk Incurred Claims = **L(9)-L(10)**						XXX	
(12)	Underwriting Risk Claims Ratio = For Column (1) through (5), **L(11)/L(6)**						1.000	XXX
(13)	Underwriting Risk Factor*					0.130	0.130	XXX
(14)	Base Underwriting Risk RBC **= L(6) x L(12) x L(13)**							
(15)	Managed Care Discount Factor						XXX	XXX
(16)	RBC After Managed Care Discount **= L(14) x L(15)**						XXX	
(17) †	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(18)	Alternate Risk Charge **						XXX	XXX
(19)	Alternate Risk Adjustment						XXX	XXX
(20)	Net Alternate Risk Charge***						XXX	
(21)	Net Underwriting Risk RBC (MAX{**L(16),L(20)**}) for Columns (1) through (5), Column (6), **L(14)**							

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

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page 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.

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)		**Medicaid Pass-Through Payments Reported as Premiums**		**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	
(9)		Underwriting Risk Revenue = L(4)+L(5)+L(6)+L(7)-**L(8)**							
(10)		Individual Net Incurred Claims		XXX		XXX	XXX	XXX	
(11)		Small Group Net Incurred Claims		XXX		XXX	XXX	XXX	
(12)		Large Group Net Incurred Claims		XXX		XXX	XXX	XXX	
(13)	†	Title XVIII-Medicare Net Incurred Claims		XXX	XXX	XXX	XXX	XXX	
(14)	†	Title XIX-Medicaid Net Incurred Claims		XXX	XXX	XXX	XXX	XXX	
(15)		Other Health Net Incurred Claims		XXX				XXX	
(16)	†	Total Net Incurred Claims							
(17)		**Medicaid Pass-Through Payments Reported as Claims**		**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	
(18)	†	**Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = L(16)-L(17)**							
(19)	†	Fee-For-Service Offset		XXX				XXX	
(20)		Underwriting Risk Incurred Claims =**L(18)-L(19)**						XXX	
(21)		Individual Underwriting Risk Claims Ratio =**L(10)**/L(1)		XXX		XXX	XXX	XXX	XXX
(22)		Small Group Underwriting Risk Claims Ratio =**L(11)**/L(2)		XXX			XXX	XXX	XXX
(23)		Large Group Underwriting Risk Claims Ratio =**L(12)**/L(3)		XXX		XXX	XXX	XXX	XXX
(24)		Title XVIII-Medicare Underwriting Risk Claims Ratio =**L(13)**/L(5)		XXX	XXX	XXX	XXX	XXX	XXX
(25)		Title XIX-Medicaid Underwriting Risk Claims Ratio =**L(14)**/L(6)		XXX	XXX	XXX	XXX	XXX	XXX
(26)		Other Health Underwriting Risk Claims Ratio =**L(15)**/L(7)		XXX				XXX	XXX
(27)		Underwriting Risk Claims Ratio = For Column (1) through (5),**L(20)/L(9)**						1.000	XXX
(28)		Underwriting Risk Factor*					0.130	0.130	XXX
(29)		Base Underwriting Risk RBC **= L(9) x L(27) x L(28)**							
(30)		Managed Care Discount Factor						XXX	XXX
(31)		RBC after Managed Care Discount **= L(29) x L(30)**						XXX	
(32)	†	Maximum Per-Individual Risk After Reinsurance						XXX	XXX
(33)		Alternate Risk Charge **						XXX	XXX
(34)		Alternate Risk Adjustment						XXX	XXX
(35)		Net Alternate Risk Charge***						XXX	
(36)		Net Underwriting Risk RBC (MAX{**L(31),L(35)**}) for Columns (1) through (5), Column (6), **L(29)**							

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.

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 **(16)** into Lines (1) through (3) and Lines **(10)** through **(12)**, 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 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)_____. 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.

± The percentage breakout of Line (1), Column (1) should equal 100% of Footnote 3(a) and 3(b) and the percentage breakout of Line **(10)**, Column (1) should equal 100% of Footnote 3(c) and 3(d).

†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, C2, L4	XXX	P7, C4 & C5, L4			XXX	
(7)	Net Incurred Claims	P7, C2 +C7 +C8, L17	P7, C3, L17	P7, C4 & C5, L17			XXX	
(10)	Fee-For-Service Offset	P7, C2, L3	XXX	P7, C4 & C5 , L3			XXX	
(17)	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.

† **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
(13)	Title XVIII-Medicare Net Incurred Claims	P7, C7, L17	XXX			XXX	XXX	0
(14)	Title XIX-Medicaid Net Incurred Claims	P7, C8, L17	XXX			XXX	XXX	0
(16)	Net Incurred Claims	P7, C2 + C7 + C8, L17	P7, C3, L17	P7, C4 & C5, L17			XXX	0
(19)	Fee-For-Service Offset	P7, C2, L3	XXX	P7, C4 & C5 L3			XXX	0
(32)	Maximum Per-Individual Risk After Reinsurance	Gen Int Pt 2 5.31+ 5.32	Gen Int Pt 2 5.33	Gen Int Pt 2, L5.34			XXX	XXX

HEALTH PREMIUMS and HEALTH CLAIMS RESERVES

LR019, LR023 and LR024

Basis of Factors

Risk-based capital factors for health insurance are applied to medical and disability income, long-term care insurance and other types of health insurance premiums and Exhibit 6 claim reserves with an offset for premium stabilization reserves. For health coverage that does not fit into one of the defined categories for risk-based capital, the "Other Health" category is to be used.

Medical Insurance Premium

The business is subdivided by product into categories for individual coverages and for group and credit coverages depending on the risk related to volatility of claims. The factors were developed from a model that determines the minimum amount of surplus needed to protect the company against a worst-case scenario for each type of coverage. The results of the model were then translated into either a uniform percentage or a two-tier formula to be applied to premium. The two-tier formula reflects the decreased risk of a larger in-force block. The formula includes several changes starting in 1998 for some types of health insurance. These changes add several worksheets and are designed to keep the RBC amounts for health coverage consistent regardless of the RBC formula used. If the company has comprehensive medical business, medicare supplement, dental business, or Stand-Alone Medicare Part D coverage through a PDP arrangement, it will be directed to these additional worksheets. The instructions for including paid health claims in the various categories of the Managed Care Discount Factor Calculation can be found in the instructions to LR022 Underwriting Risk – Managed Care Credit. Appendix 2 of these instructions lists commonly used health insurance terms. Appendix 3 of these instructions lists commonly used terms specific to Stand-Alone Medicare Part D coverage. If the company has any of the four mentioned types of medical insurance, it will also be required to complete additional parts of the formula for C-3 Health Credit Risk and C-4 Health Administrative Expenses Risk portion of the Business Risk.

Disability Income Premium

Prior to 2001, the individual disability income factors were based on models of the disability risk completed by several companies with significant experience in this line. The group long-term disability income risk was modeled based on methodology similar to that used by one of the largest writers of this business. The pricing risk was addressed principally as the delayed reaction to increases in incidence of new claims and to the lengthening of claims from slower recoveries than assumed.

Starting in 2001, new categories and new factors are applicable to all types of disability income premiums. These factors are based on new data and apply a model similar to that used for other health premium risk to that data.

Long-Term Care Insurance Premium

Prior to 2005, factors equal to the original disability income factors were used. Starting in 2005, factors based on LTC experience replaced those factors. The difference in the factor**s** used in 2004 and prior years for noncancellable LTC versus other LTC has been retained as a rate risk factor applied to the NC premium. The morbidity risk is partially applied directly to premium with a higher factor applied to amounts up to $50,000,000 and a lower factor 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 LTC Claims for RBC. A higher factor is applied to claims up to $35,000,000 and a lower factor is applied to claims above $35,000,000.

Claim Reserves

Additional risk-based capital of 5 percent of claim reserves for both individual and group and credit is required to recognize the risk of the level of recoveries and other claim terminations falling below that assumed in the development of claim reserves. However, claims reserves for workers' compensation carve-out are excluded from this charge and are separately assessed risk-based capital on page LR021 Underwriting Risk – Other, Line (5); reserves entered for this exclusion should be reported in net balance sheet reserves in Schedule P, Part 1 of the Workers Compensation Carve-Out Supplement.

Pre-Tax and Post-Tax Factors

The formula uses pre-tax factors for all types of health insurance. Because many insurers of some types of health insurance write very little other business, it was determined that there would be no difference between pre-tax and post-tax factors except where substantial investment income is assumed as part of the product pricing. Thus, for disability income, the pre-tax factors in the table below and in LR023 Long-Term Care will be adjusted to post-tax by applying a tax-effect change to RBC in LR030 Calculation of Tax Effect for Life Risk-Based Capital. For reasons of practicality and simplicity, credit disability is included with other disability income and adjusted to post-tax. The pre-tax RBC values for other types of health insurance will not be adjusted.

Specific Instructions for Application of the Formula

The total of all earned premium categories LR019 Health Premiums, Line (31), Column (1) should equal the total in Schedule H, Part 1, Line 2, Column 1 of the annual statement. Earned premium for each of these coverages should be from underlying company records. Earned premium may be reported in Schedule H for Administrative Services Contracts (ASC) and/or the Federal Employees Health Benefits Plan (FEHBP) and/or Workers Compensation Carve-Out, which are included in order that Line (31) will equal the total in Schedule H. As such, there is no RBC factor applied to any premium reported on Lines (18), (28) or (29). For some of the coverages, two-tier formulas apply. The calculations for these coverages shown below will not appear on the RBC filing software but will automatically be calculated by the software.

Line (1)
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (1), Line (1.1).

Line (2)
Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (2), Line (1.1).

Line (3)
Health premiums for dental or vision coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (3), Line (1.1).

Line (4)
Health premium for Stand-Alone Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 3 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (1). No RBC requirement is calculated in Column (2). The premium is carried forward to page LR020 Underwriting Risk – Experience Fluctuation Risk Column (4) Line (1.1).

Line (5)
Health **incurred claims** for Supplemental benefits within Stand-Alone Medicare Part D coverage written on individual contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible. This does not include the low-income subsidy (cost sharing portion), which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Stand-Alone Medicare Part D Coverage on LR019.

Line (6) and (16)
Medicaid pass-through payments reported as premium and excluded from Line (1) should be reported in Line (6) or (16).

Line (~~7~~6) and Line (1~~5~~7)
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 (~~8~~7) and Line (1~~8~~6)
The factor for accidental death and dismemberment (AD&D) insurance (where a single lump sum is paid) depends on several items:

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

There are places for reporting the total amount of earned premium and the maximum retained risk on any single claim. The actual RBC Requirement will be calculated automatically as the sum of (a) the lesser of items 1 and 2 plus (b) items 3 plus 4.

Line (~~9~~8) and Line (1~~7~~9)
The factor for Other Accident coverage provides for any accident-based contingency other than those contained in Lines (7) or (16). 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 also be shown on this line.

Line (10~~9~~)
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (1), Line (1.2).

Line (1~~0~~1)
Health premiums for dental or vision coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (3), Line (1.2).

Line (12~~1~~)
The American Academy of Actuaries submitted a report to the Health Risk-Based Capital Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical. It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first $25,000,000 in premium and a factor of 25 percent will be applied to the premium in excess of $25,000,000.

Line (1~~2~~3)
Health premiums for Medicare supplement written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to LR020 Underwriting Risk – Experience Fluctuation Risk, Column (2), Line (1.2).

Line (1~~3~~4)
Health premium for Stand-Alone Medicare Part D coverage written on group contracts only if the plan sponsor has risk corridor protection for the contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor protection payments. See Appendix 3 for definition of these terms. Stand-Alone Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (30) Other Health. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (9). No RBC requirement is calculated in Column (2). The premium is carried forward to page LR020 Underwriting Risk – Experience Fluctuation Risk Column (4) Line (1.2).

Line (145)

Health **incurred claims** for Supplemental benefits within Stand-Alone Medicare Part D coverage written on group contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible where the plan sponsor has risk corridor protection for the group contract's standard benefit design coverage. This does not include the low-income subsidy (cost-sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Part D Coverage on LR019.

Lines (2119) through (257)

Disability income premiums are to be separately entered depending upon category (individual and group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.) For group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of group and credit are combined in a different category from individual.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 19) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b) etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

	Disability Income Premium	Annual Statement Source	(1) Statement Value	Factor	(2) RBC Requirement
Line (2119)	Noncancellable Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	First $50 Million Earned Premium of Line (2119)	Company Records		X 0.539 =	
b)	Over $50 Million Earned Premium of Line (2119)	Company Records		X 0.231 =	
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (2119) + b) of Line (2119), Column (2)			
Line (220)	Other Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	Earned Premium in Line (220) [up to $50 million less premium in a) of Line (2119)]	Company Records		X 0.385 =	
b)	Earned Premium in Line (202) not included in a) of Line (202)	Company Records		X 0.108 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (202) + b) of Line (220), Column (2)			

Line (2~~1~~3)		Disability Income - Credit Monthly Balance	Earned Premium included in Schedule H, Part 1, Line 2, in part			
	a)	First $50 Million Earned Premium of Line (2~~1~~3)	Company Records		X 0.308 =	
	b)	Over $50 Million Earned Premium of Line (2~~3~~1)	Company Records		X 0.046 =	
	c)	Total Disability Income - Credit Monthly Balance	a) of Line (2~~1~~3) + b) of Line (2~~1~~3), Column (2)			
Line (2~~2~~4)		Disability Income – Group Long-Term	Earned Premium included in Schedule H, Part 1, Line 2, in part			
	a)	Earned Premium in Line (2~~2~~4) [up to $50 million less premium in a) of Line (2~~1~~3)]	Company Records		X 0.231 =	
	b)	Earned Premium in Line (2~~2~~4) not included in a) of Line (2~~2~~4)	Company Records		X 0.046 =	
	c)	Total Disability Income – Group Long-Term	a) of Line (2~~2~~4) + b) of Line (2~~2~~4), Column (2)			
Line (2~~3~~5)		Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part. This amount to be reported on LR019 Health Premiums, Line (2~~5~~3)			
	a)	Additional Reserves for Credit Disability Plans	LR019 Health Premiums Column (1) Line (3~~2~~4)			
	b)	Additional Reserves for Credit Disability Plans, Prior Year	LR019 Health Premiums Column (1) Line (3~~5~~3)			
	c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (2~~5~~3) - a) of Line (2~~5~~3) + b) of Line (2~~3~~5)			
	d)	Earned Premium in c) [up to $50 million less premium in a) of Line (2~~3~~1) + a) of Line (2~~4~~2)]	Company Records		X 0.231 =	
	e)	Earned Premium in c) of Line (2~~5~~3) not included in d) of Line (2~~5~~3)	Company Records		X 0.046 =	
	f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (2~~3~~5) + e) of Line (2~~5~~3), Column (2)			
Line (2~~4~~6)		Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part			
	a)	Earned Premium in Line (2~~4~~6) [up to $50 million less premium in a) of Line (2~~1~~3) + a) of Line (2~~2~~4) + d) of Line (2~~3~~5)]	Company Records		X 0.154 =	
	b)	Earned Premium in Line (2~~4~~6) not included in a) of Line (2~~4~~6)	Company Records		X 0.046 =	
	c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (2~~4~~6) + b) of Line (2~~4~~6), Column (2)			
Line (2~~5~~7)		Disability Income – Group Short-Term	Earned Premium included in Schedule H, Part 1, Line 2, in part			
	a)	Earned Premium in Line (2~~5~~7) [up to $50 million less premium in a) of Line (2~~1~~3) + a) of Line (2~~2~~4) + d) of Line (2~~5~~3) + a) of Line (2~~4~~6)]	Company Records		X 0.077 =	
	b)	Earned Premium in Line (2~~5~~7) not included in a)	Company Records			

	of Line (2~~5~~7)				
c)	Total Disability Income – Group Short-Term	a) of Line (2~~5~~7) + b) of Line (2~~5~~7), Column (2)		X 0.046 =	

Lines (2~~6~~8) and (2~~7~~9)

Premiums for noncancellable long-term care insurance are included on Line (26) to reflect the additional risk when rate increases are not permitted. Line (27) includes premiums for Other LTC coverage but with no RBC value on this page (the RBC is determined on LR023 Long-Term Care) so that the validation check to Schedule H can still be performed.

Line (31~~29~~)

Premiums for Workers' Compensation Carve-Out are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The RBC Requirement assessed on these premiums can be found on page LR021 Underwriting Risk – Other, Line (4).

Line (3~~2~~0)

It is anticipated that most health premium will have been included in one of the other lines. In the event that some coverage does not fit into any of these categories, the "Other Health" category continues the RBC factor from the 1998 and prior formula for Other Limited Benefits Anticipating Rate Increases.

HEALTH PREMIUMS

			Annual Statement Source	(1) Statement Value		Factor		(2) RBC Requirement	
	Medical Insurance Premiums - Individual Morbidity								
(1)	Usual and Customary Major Medical and Hospital		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(2)	Medicare Supplement		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(3)	Dental and Vision		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(4)	Stand-Alone Medicare Part D Coverage		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(5)	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred		Company Records		X	0.500	=		
(6)	**Medicaid Pass-Through Payments Reported as Premium**		**Company Records**	**0**	**x**	**0.02**	**=**		
(7)	Hospital Indemnity and Specified Disease		Earned Premium (Schedule H Part 1 Line 2 in part)		X	*	=		
(8)	AD&D (Maximum Retained Risk Per Life	)	Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(9)	Other Accident		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.050	=		
	Medical Insurance Premiums - Group and Credit Morbidity								
(10)	Usual and Customary Major Medical, Hospital		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(11)	Dental and Vision		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(12)	Stop Loss and Minimum Premium		Earned Premium (Schedule H Part 1 Line 2 in part)		X	¥	=		
(13)	Medicare Supplement		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(14)	Stand-Alone Medicare Part D Coverage (see instructions for limits)		Earned Premium (Schedule H Part 1 Line 2 in part)			†		XXX	
(15)	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred		Company Records		X	0.500	=		
(16)	**Medicaid Pass-Through Payments Reported as Premium**		**Company Records**	**0**	**x**	**0.02**	**=**		
(17)	Hospital Indemnity and Specified Disease		Earned Premium (Schedule H Part 1 Line 2 in part)		X	*	=		
(18)	AD&D (Maximum Retained Risk Per Life)	)	Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(19)	Other Accident		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.050	=		
(20)	Federal Employee Health Benefit Plan		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.000	=		
	Disability Income Premium								
(21)	Noncancellable Disability Income - Individual Morbidity		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(22)	Other Disability Income - Individual Morbidity		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(23)	Disability Income - Credit Monthly Balance Plans		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(24)	Disability Income - Group Long-Term		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(25)	Disability Income-Credit Single Premium with Additional Reserve		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(26)	Disability Income-Credit Single Premium without Additional Reserves		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
(27)	Disability Income - Group Short-Term		Earned Premium (Schedule H Part 1 Line 2 in part)		X	‡	=		
	Long-Term Care								
(28)	Noncancellable Long-Term Care Premium - Rate Risk**		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.154**	=		
(29)	Other Long-Term Care Premium ‡‡		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.000	=		‡‡
	Health Premium With Limited Underwriting Risk								
(30)	ASC Business Reported as Revenue Premium		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.000	=		
	Other Health								
(31)	Workers Compensation Carve-Out		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.000	=		
(32)	Other Health		Earned Premium (Schedule H Part 1 Line 2 in part)		X	0.120	=		
(33)	Total Earned Premiums		Sum of Lines (1) through (32)						
	(Column (1) should equal Schedule H Part 1 Column 1 Line 2)								
(34)	Additional Reserves for Credit Disability Plans		Exhibit 6, Column 3, Line 2		§				
(35)	Additional Reserves for Credit Disability Plans, prior year		Exhibit 6, Column 3, Line 2, prior year		§				

† The premium amounts in these lines are transferred to LR020 Underwriting Risk – Experience Fluctuation Risk Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amoun are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete LR022 Underwriting Risk – Manage Care Credit. In which case, the company will also need to complete LR028 Health Credit Risk in the (C-3) portion of the formula. If there are amounts in any of lines (1), (2), (3 **(10), (11) or (13)** on page LR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of LR029 Business Risk in the (C-4) portion of the formul

‡ The two tiered calculation is illustrated in the risk-based capital instructions for LR019 Health Premiums

‡‡ The balance of the RBC requirement for Long Term Care - Morbidity Risk is calculated on page LR023. The premium is shown to allow totals to check to Schedule H

* If there is premium included on either or both of these lines, the RBC requirement in Column (2) will include 3.5 percent of such premium and $50,000 (included in the line with the larger premium

** The factor applies to all Noncancellable premium

§ These amounts are used to adjust the premium base for single premium credit disability plans that carry additional tabular reserve

¥ A factor of .350 will be applied to the first $25,000,000 in Column (1), Line **(12)** and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

Denotes items that must be manually entered on the filing software

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

If the reporting company writes 5 percent or more of its premiums in A&H lines in **2015**, **2016** or **2017**, this section of the formula must be completed. To determine if that applies, take the sum of Lines 13, 14 and 15 of the Underwriting and Investment Exhibit Part 1B Column 6 and divide by Line 35 Column 6, and round to three decimals for each individual year. If the result is at least 0.050 in any year, this exhibit and the appropriate Schedule P adjustment must be completed.

If the company writes less than 5 percent of its premiums in A&H lines in **2015**, **2016** and **2017**, disregard this section.

PR019 - Health Premiums

Basis of Factors

Risk-based capital factors for health insurance are applied to medical, disability income, long-term care insurance and other types of health insurance premiums and claim reserves with an offset for premium stabilization reserves. For health coverage that does not fit into one of the defined categories for risk-based capital, the "Other Health" category is to be used.

Medical Insurance Premium

The business is subdivided by product into categories for individual coverages and for group and credit coverages depending on the risk related to volatility of claims. The factors were developed from a model that determines the minimum amount of surplus needed to protect the company against a worst-case scenario for each type of coverage. The results of the model were then translated into either a uniform percentage or a two-tier formula to be applied to premium. The two-tier formula reflects the decreased risk of a larger in-force block. The formula includes several changes starting in 1999 for some types of health insurance. These changes add several additional worksheets and are designed to keep the RBC amounts for health coverage consistent regardless of the RBC formula used. If the company has Comprehensive Medical business, Medicare Supplement, Dental & Vision business, or Stand-Alone Medicare Part D coverage through a PDP arrangement, it will be directed to these additional worksheets. The instructions for including paid health claims in the various categories of the Managed Care Discount Factor Calculation can be found in the instructions to PR021 Underwriting Risk – Managed Care Credit. Appendix 1 - Commonly Used Health Insurance Terms has been added to these instructions. Appendix 2 of these instructions lists commonly used terms of Stand-Alone Medicare Part D coverage. If the company has any of the three mentioned types of medical insurance, it will also be required to complete additional parts of the formula for Health Credit Risk (PR013) and Health Administrative Expenses portion in PR022.

Disability Income Premium

Prior to 2001, the individual disability income factors were based on models of the disability risk completed by several companies with significant experience in this line. The group long-term disability income risk was modeled based on methodology similar to that used by one of the largest writers of this business. The pricing risk was addressed principally as the delayed reaction to increases in incidence of new claims and to the lengthening of claims from slower recoveries than assumed.

Starting in 2001, new categories and new factors are applicable to all types of disability income premiums. These factors are based on new data and apply a model similar to that used for other health premium risk to that data.

Specific Instructions for Application of the Formula

The total of all earned premium categories PR019 Health Premiums, Line (26), Column (1) should equal the total in Schedule H, Part 1, Line 2, Column 1 of the Annual Statement. Earned premium for each of these coverages should be from underlying company records. Earned premium may be reported in Schedule H for Administrative Services Contract (ASC) and/or the Federal Employees Health Benefit Program (FEHBP) which are included in order that Line (26) will equal the total in Schedule H. As such, there is no RBC factor applied to any premium reported on lines (14), (23) or (24). For some of the coverages, two tier formulas apply. The calculations for these coverages shown below will not appear on the CD-ROM but will automatically be calculated by the software.

Line (1)
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (1) Line (1.1). Medicaid Pass-Through Payments reported as premium in the annual statement filing should be excluded from the premium amounts reported in Line 1 and reported in Line (3.3) and (10.3), respectively.

Line (2)
Health premiums for Medicare supplement written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (2) Line (1.1).

Line (3)
Health premiums for dental or vision coverage written on individual contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.1).

Line (3.1)
Health **incurred claims** for Stand-Alone Medicare Part D coverage written on individual contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor payment adjustments. See Appendix 2 for definition of these terms. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (1). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.1).

Line (3.2)
Health **incurred claims** for Supplemental benefits within Stand-Alone Medicare Part D coverage written on individual contracts that is beneficiary payment (supplemental benefit portion) – e.g. coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible. This does not include the low-income subsidy (cost sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Stand-Alone Medicare Part D Coverage on PR019.

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

Line (4) and Line (11)
There is a factor for certain types of limited benefit coverage (Hospital Indemnity, which includes a per diem for intensive care facility stays, and Specified Disease) which includes both a percent of earned premium on such insurance (3.5 percent) and a flat dollar amount ($50,000) to reflect the higher variability of small amounts of business.

Line (5) and Line (12)
There is a factor for accidental death and dismemberment (AD&D) insurance (where a single lump sum is paid) which depends on several items:

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

There are places for reporting the total amount of earned premium and the maximum retained risk on any single claim. The actual RBC amount will be calculated automatically as the sum of (a) the lesser of items 1 and 2; plus (b) items 3 plus 4.

Line (6) and Line (13)
A 5 percent factor for Other Accident coverage provides for any accident based contingency other than those contained in Lines (5) or (12). For example, this line should contain all the premium for policies that provide coverage for accident only disability or accident only hospital indemnity. The premium for policies that contain AD&D in addition to other accident only benefits should be shown on this line.

Line (7)
Health premiums for usual and customary major medical and hospital (including comprehensive major medical and expense reimbursement hospital/medical coverage) written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (1) Line (1.2).

Line (8)
Health premiums for dental or vision coverage written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (3) Line (1.2).

Line (9)
The American Academy of Actuaries submitted a report to the Health Risk-Based Capital Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical. It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first $25,000,000 in premium and a factor of 25 percent will be applied to the premium in excess of $25,000,000.

Line (10)
Health premiums for Medicare supplement written on group contracts are entered in Column (1) for this line, but no RBC Requirement is calculated in Column (2). The premiums are carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (2) Line (1.2).

Line (10.1)
Health premium for Stand-Alone Medicare Part D coverage written on group contracts only if the plan sponsor has risk corridor protection for the contracts - includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D Payment Demonstration amounts and risk corridor protection payments. See Appendix 2 for definition of these terms. Stand-Alone Medicare Part D coverage written on group contracts without risk corridor protection is reported in Line (25) Other Health. This does not include Medicare-Advantage prescription drug coverage (MA-PD) premiums which are to be included in Line (9). No RBC requirement is calculated in Column (2). The premium is carried forward to page PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement and Dental & Vision, Column (4) Line (1.2).

Line (10.2)
Health **Incurred Claims** for Supplemental benefits within Stand-Alone Medicare Part D coverage written on group contracts that is beneficiary payment (supplemental benefit portion) – e.g., coverage in the coverage gap, use of co-pays of less value than the minimum regulatory coinsurance and reduced deductible where the plan sponsor has risk corridor protection for the group contract's standard benefit design coverage. This does not include the low-income subsidy (cost-sharing portion) which is not a component of reported revenue. RBC is calculated for Supplemental benefits within Part D Coverage on PR019.

Line (10.3)

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

Lines (15) through (24)

Disability income premiums are to be separately entered depending on category (Individual and Group). For Individual, a further split is between noncancellable (NC) or other (GR, etc.) For Group, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). For long-term care insurance, premiums are reported separately for Individual noncancellable, Individual (other than NC) and Group LTCI. The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below $50,000,000 for similar types. Starting in 2001, in determining the premiums subject to the higher factors, individual disability income noncancellable and other is combined. All types of Group and Credit are combined in a different category from Individual. For long-term care, all types (Individual and Group) are combined.

The following table describes the calculation process used to assign RBC charges to disability income business. The reference to line numbers (e.g., Line 15) represent the actual line numbers used in the formula page, but the subdivisions of those lines [e.g., a), b), etc.] do not exist in the formula page. The total RBC Requirement shown in the last (Total) subdivision of each line will be included in Column (2) for that line in the formula page.

		Annual Statement Source	Statement Value	Factor	RBC Requirement
	Disability Income Premium				
Line (15)	Noncancellable Disability Income - Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	First $50 Million Earned Premium of Line (15)	Company Records		X 0.350 =	
b)	Over $50 Million Earned Premium of Line (15)	Company Records		X 0.150 =	
c)	Total Noncancellable Disability Income - Individual Morbidity	a) of Line (15) + b) of Line (15), Column (2)			
Line (16)	Other Disability Income – Individual Morbidity	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	Earned Premium in Line (16) [up to $50 million less premium in a) of Line (15)]	Company Records		X 0.250 =	
b)	Earned Premium in Line (16) not included in a) of Line (16)	Company Records		X 0.070 =	
c)	Total Other Disability Income - Individual Morbidity	a) of Line (16) + b) of Line (16), Column (2)			
Line (17)	Disability Income - Credit Monthly Balance	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	First $50 Million Earned Premium of Line (17)	Company Records		X 0.200 =	
b)	Over $50 Million Earned Premium of Line (17)	Company Records		X 0.030 =	
c)	Total Disability Income - Credit Monthly Balance	a) of Line (17) + b) of Line (17), Column (2)			
Line (18)	Disability Income – Group Long Term	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	Earned Premium in Line (18) [up to $50 million less premium in a) of Line (17)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (18) not included in a) of	Company Records		X 0.030 =	

		Annual Statement Source	Statement Value	Factor	RBC Requirement
	Disability Income Premium Line (18)				
c)	Total Disability Income – Group Long Term	a) of Line (18) + b) of Line (18), Column (2)			
Line (19)	Disability Income - Credit Single Premium with Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part. This amount to be reported on Health Premiums, Line (19)			
a)	Additional Reserves for Credit Disability Plans	PR019 Health Premiums Column (1) Line (27)			
b)	Additional Reserves for Credit Disability Plans, Prior Year	PR019 Health Premiums Column (1) Line (28)			
c)	Subtotal Disability Income - Credit Single Premium with Additional Reserves	Line (19) - a) of Line (19) + b) of Line (19)			
d)	Earned Premium in c) [up to $50 million less premium in a) of Line (17) + a) of Line (18)]	Company Records		X 0.100 =	
e)	Earned Premium in c) of Line (19) not included in d) of Line (19)	Company Records		X 0.030 =	
f)	Total Disability Income - Credit Single Premium with Additional Reserves	d) of Line (19) + e) of Line (19), Column (2)			
Line (20)	Disability Income – Credit Single Premium without Additional Reserves	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	Earned Premium in Line (20) [up to $50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19)]	Company Records		X 0.150 =	
b)	Earned Premium in Line (20) not included in a) of Line (20)	Company Records		X 0.030 =	
c)	Total Disability Income – Credit Single Premium without Additional Reserves	a) of Line (20) + b) of Line (20), Column (2)			
Line (21)	Disability Income – Group Short Term	Earned Premium included in Schedule H, Part 1, Line 2, in part			
a)	Earned Premium in Line (21) [up to $50 million less premium in a) of Line (17) + a) of Line (18) + d) of Line (19) + a) of Line (20)]	Company Records		X 0.050 =	
b)	Earned Premium in Line (21) not included in a) of Line (21)	Company Records		X 0.030 =	
c)	Total Disability Income – Group Short Term	a) of Line (21) + b) of Line (21), Column (2)			
Line (22)	Noncancellable Long-Term Care Premium – Rate risk	Earned Premium (Schedule H, Part 1, Line 2, in part)		X 0.100 =	

Line (25)

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

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			(1)		(2)	
	Medical Insurance Premium - Individual Morbidit	Annual Statement Source	Statement Value	Factor	RBC Requirement	
(1)	Usual and Customary Major Medical and Hospital	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(2)	Medicare Supplement	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(3)	Dental & Vision	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(3.1)	Stand-Alone Medicare Part D Coverage	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(3.2)	Supplemental Benefits within Stand-Alone Part D Coverage (Claims Incurred)	Company Records	0	0.500		0
(3.3)	**Medicaid Pass-Through Payments Reported as Premium**	**Company Records**	**0**	**0.020**		**0**
(4)	Hospital Indemnity and Specified Disease	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.035	*	0
(5)	AD&D (Maximum Retained Risk Per Life 0)	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(6)	Other Accident	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.050		0
	Medical Insurance Premium - Group and Credit Morbidity					
(7)	Usual and Customary Major Medical, Hospital	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(8)	Dental & Vision	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(9)	Stop Loss and Minimum Premium	Earned Premium (Schedule H Part 1 Line 2 in part)	0	¥		0
(10)	Medicare Supplement	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(10.1)	Stand-Alone Medicare Part D Coverage (see instructions for limits)	Earned Premium (Schedule H Part 1 Line 2 in part)	0	†	XXX	
(10.2)	Supplemental benefits within Stand-Alone Part D Coverage (Claims Incurred)	Company Records	0	0.500		0
(10.3)	**Medicaid Pass-Through Payments Reported as Premium**	**Company Records**	**0**	**0.020**		**0**
(11)	Hospital Indemnity and Specified Disease	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.035	*	0
(12)	AD&D (Maximum Retained Risk Per Life 0)	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(13)	Other Accident	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.050		0
(14)	Federal Employee Health Benefit Plan	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.000		0
	Disability Income Premium					
(15)	Noncancellable Disability Income - Individual Morbidity	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(16)	Other Disability Income - Individual Morbidity	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(17)	Disability Income - Credit Monthly Balance Plans	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		
(18)	Disability Income - Group Long-Term	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(19)	Disability Income - Credit Single Premium with Additional Reserve	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(20)	Disability Income - Credit Single Premium without Additional Reserve	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
(21)	Disability Income - Group Short-Term	Earned Premium (Schedule H Part 1 Line 2 in part)	0	‡		0
	Long-Term Care					
(22)	Noncancellable Long-Term Care Premium - Rate Risk**	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.100		0
(23)	Other Long-Term Care Premium ‡ ‡	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.000		0 ‡ ‡
	Health Premium with Limited Underwriting Risk					
(24)	ASC Business with Premium Revenue	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.000		0
	Other Health					
(25)	Other Health	Earned Premium (Schedule H Part 1 Line 2 in part)	0	0.120		0
(26)	Total Earned Premiums	Sum of Lines (1) through (25)	0			0
	C(1), L(26) should equal Schedule H Part 1 Column 1 Line 2					
(27)	Additional Reserves for Credit Disability Plans	Company records	0	§		
(28)	Additional Reserves for Credit Disability Plans, prior year	Company records	0	§		

† The premium amounts in these lines are transferred to PR020 Underwriting Risk – Premium Risk for Comprehensive Medical, Medicare Supplement, Dental & Vision and Stand-Alone Medicare Part D Coverage Lines (1.1) and (1.2) for the calculation of risk-based capital. The premium amounts are included here to assist in the balancing of total health premium. If managed care arrangements have been entered into, the company may also complete PR021 Underwriting Risk – Managed Care Credit. In which case, the company will also need to complete PR012 Health Credit Risk in the formula. If there are amounts in any of lines (1), (2), (3), (7), (8) or (10) on page PR019 Health Premiums, the company will also be directed to complete the Health Administrative Expense portion of PR023.

‡ The two tiered calculation is illustrated in the risk-based capital instructions for PR019 Health Premiums.

‡ ‡ The balance of the RBC requirement for Long Term Care - Morbidity Risk is calculated on Page PR023. The premium is shown to allow totals to check to Schedule H.

* If there is premium included on either or both of these lines, the RBC value in Column (2) will include 3.5% of such premium and $50,000 (included in the line with the larger premium).

** The factor applies to all Noncancellable premium.

§ These amounts are used to adjust the premium base for single premium credit disability plans that carry additional tabular reserves.

¥ A factor of .350 will be applied to the first $25,000,000 in Column (1), Line (9) and a factor of .250 will be applied to the remaining premium in excess of $25,000,000.

Denotes items that must be manually entered on the filing software.