Capital Adequacy (E) Task Force

RBC Proposal Form

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

		FOR NAIC USE ONLY
	DATE: 2-26-18	Agenda Item # 2018-04-H
CONTACT PERSON:	**Crystal Brown**	Year 2018
TELEPHONE:	**816-783-8146**	**DISPOSITION**
EMAIL ADDRESS:	**cbrown@naic.org**	[x] ADOPTED 6-28-18
ON BEHALF OF:	**Health RBC (E) Working Group**	[ ] REJECTED ______
NAME:	**Patrick McNaughton**	[ ] DEFERRED TO ______
TITLE:	**Chief Financial Examiner/Chair**	[ ] REFERRED TO OTHER NAIC GROUP
AFFILIATION:	**WA Office of Insurance Commissioner**	[x] EXPOSED 4-24-18
ADDRESS:	**PO Box 40255**	[ ] OTHER (SPECIFY) ______
	Olympia, WA 98504-0255	

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

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

DESCRIPTION OF CHANGE(S)

Add language to the instructions for Line 1 and 6 on page XR012 for beneficiary premium and incurred claims for stand-alone Medicare Part D coverage.

REASON OR JUSTIFICATION FOR CHANGE **

Add clarifying language to the page XR012 instructions for Line 1 and 6 that beneficiary premium and incurred claims are excluded for Stand-Alone Medicare Part D coverage. Language was also added to report the incurred claims amount on page XR014, Line 22.1.

Additional Staff Comments:

3-25-18 cgb The WG exposed the proposal for a 30-day comment period ending on April 24, 2018
4-25-18 cgb No comments were received.
5-18-18 cgb The WG adopted the proposal.
6-28-18 cgb The Capital Adequacy (E) Task Force adopted the proposal.

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

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UNDERWRITING RISK - L(1) THROUGH L(18)
XR012

Detail Eliminated To Conserve Space

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. **Also exclude the** ~~B~~**b**eneficiary premium (supplemental benefit portion) **for Stand-Alone Medicare Part D coverage** ~~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) Underwriting Risk Revenue. The sum of Lines (1) through (4).

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

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in Appendix 2). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. **Exclude the Beneficiary incurred claims (supplemental benefit portion) for Stand-alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (22.1) of XR014.**

Detail Eliminated To Conserve Space