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Financial Reporting Implications Under the Affordable Care Act

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American Academy of Actuaries
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Executive Summary

As 2014 approaches, the market reforms introduced by the Affordable Care Act (ACA) may create uncertainty for health insurance issuers above and beyond the changes that have occurred in the first three years after enactment. Much of this uncertainty surrounds the risk that customer behavior in the reformed market may deviate from the projections made by each issuer in its pricing and strategic decisions.

Another element has received comparatively less attention—the extent that an issuer's future financial statements may be subject to additional volatility due to the ACA because of an increased need for actuarial estimates in financial reporting. The purpose of this white paper is to address that topic, as well as new ways in which the ACA may affect financial statement comparability both among issuers and over time.[1]

This white paper provides considerations related to final, as well as proposed, ACA-related regulations issued through March 2013.[2] Any modifications made after that date to these regulations could impact some of the observations and conclusions made in this document. Further, this paper reflects the Health Practice Financial Reporting Committee's understanding of Generally Accepted Accounting Principles (GAAP) and statutory accounting guidance adopted through March 2013. Any new accounting guidance adopted also could affect observations and conclusions in this paper.

This white paper is divided into four sections, each of which discusses a category of ACA provisions that may affect health insurance issuers' financial reporting.

Section I is devoted to the impact of the ACA's premium stabilization programs, which are referred to as the 3Rs—risk adjustment, temporary reinsurance, and temporary risk corridors. These programs primarily affect the commercial individual and small-group markets starting in 2014. Since each of these programs includes a retrospective settlement process, the issuer's annual financial statements will need to include estimates of amounts payable or receivable. In some cases, the magnitude of these estimates may be large relative to the issuer's expected net income for the affected lines of business.

Section II focuses on the impact of new taxes and fees established by the ACA, with an emphasis on the Health Insurance Providers Fee (HIP fee) and the per-capita reinsurance contributions used to procure funding for the transitional reinsurance program. The introduction of these new fees, coupled with issuers' decisions on how to reflect them in pricing may alter certain financial statement metrics (e.g., medical benefit ratios (MBR)) materially. Other complicating factors

[1] This paper does not address implications for employee benefit financial reporting.

[2] In particular, this white paper was developed based on the HHS final rule, Standards Related to Reinsurance, Risk Adjustment and Risk Corridors (March 2012), as amended by the HHS final Notice of Benefit and Payment Parameters for 2014 (March 2013); the HHS final rule, Health Insurance Market Rules (February 2013); the HHS interim final rule, Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 (March 2013); and the Treasury notice of proposed rulemaking, Health Insurance Providers Fee (March 2013).

surrounding the HIP fee include its treatment as a non-deductible expense for income tax purposes and an issuer's challenge in estimating its own expense liability prior to receiving the annual assessment. Both this fee and the reinsurance contribution can lead to a revenue/expense mismatch in light of the interplay between accounting treatments and pricing actions.

Section III briefly examines issues relating to new ACA programs for which the government makes advance payments to issuers that may require subsequent adjustment: premium subsidies and cost-sharing reductions. These programs may result in significant new assets or liabilities for Dec. 31, 2014, which limits year-over-year comparability of financial statements.

Lastly, Section IV examines ways in which the 2014 market reforms may affect the existing categories of actuarial estimates found on an issuer's balance sheet, including unpaid claim liabilities, contract reserves, due and unpaid premium assets, and premium deficiency reserves.

The combination of these provisions has a number of potentially significant effects on the financial statements of health insurance issuers. These effects include:

- *Increased level of uncertainty in financial statements.* Increased uncertainty will be driven by the need to estimate the impact of risk-adjustment provisions, benefits from the transitional reinsurance program, and the seasonal pattern of incurred claims in light of significant plan design changes. The risk-corridor receivable or payable also may provide unique estimation challenges. In addition, longer lead time in the rating and rate review process may result in increased consideration of premium deficiency reserves.

- *Issues with year-to-year comparability of the balance sheet.* A number of large new assets or liabilities will create difficulties in doing year-to-year comparisons of balance sheets. Some of these assets and liabilities include transitional reinsurance program receivables, risk-adjustment receivables or payables and transitional reinsurance program assessment payables.

- *Issues with year-to-year comparability of the income statement.* The accounting treatment for certain provisions may result in year-to-year mismatches between revenue and expense, which will lead to year-to-year comparability issues in the income statements. These provisions include the HIP fee and the transitional reinsurance program contributions. In addition, the treatment of existing contract reserves for individual medical business may result in significant volatility in the income statement depending on how they are released.

- *Issues with issuer-to-issuer comparability.* The increased level of estimates (discussed above) and a few provisions for which the issuer has flexibility with regard to accounting policy or timing of payment may lead to issues regarding company-to-company comparability. The significant areas for flexibility in accounting policy or timing of payment include: treatment of reinsurance receivable on unpaid claims; whether risk-adjustment receivable/payable is estimable; timing of adding fees and transitional reinsurance assessments into premiums; and timing of payment of transitional reinsurance assessments. In addition, the impact of the HIP fee on customer premiums will vary significantly depending on the tax status of the issuer.

The cumulative effect of all of these items is that users of health insurance issuer financial statements will have to be diligent in the next few years to ensure that conclusions drawn reflect the underlying performance of the business and not just intermediate changes in treatment as a result of ACA implementation.

Section I – Premium Stabilization Programs

One of the most significant new drivers of accounting uncertainty attributable to the ACA is its premium stabilization programs, which are referred to as the 3Rs—risk adjustment, reinsurance benefits, and risk corridors. These programs primarily affect the commercial individual and small-group markets starting in 2014.[3] As such, the impact on a specific company will be somewhat dependent on its concentration in those markets.

Each of the premium stabilization programs is designed to provide protection to the health insurance issuer by mitigating adverse financial outcomes; however, these programs could have a negative effect as well. Moreover, each program includes a retrospective settlement process. As such, the issuer's annual financial statements will need to include estimates of amounts payable or receivable under these programs. As discussed below, these estimates may be uncertain in magnitude and direction, and may be large in relation to the forecasted annual net income for the affected lines of business.

A. Risk Adjustment

The risk-adjustment program is designed to allow a health insurance issuer to price and offer individual and small-group products without consideration of the underlying relative health status of the individuals purchasing these products. This concept is particularly important for the post-reform individual market since issuers can no longer employ traditional risk-management techniques, such as medical underwriting. Instead issuers must offer coverage at market rates to any applicant without regard to that applicant's health status. A high-level description of the new risk-adjustment mechanism is that the relative health status risk of each issuer's pool of insured enrollees in a given market space will be measured, and those issuers whose pools of insured enrollees have lower-than-average risk scores will transfer funds to those issuers whose pools have greater-than-average risk scores.

Risk adjustment is a closed system at the following levels: state, market (i.e., individual versus small group unless the state has formally merged the two), and risk pool (e.g., metal plans versus catastrophic plans). That is, within each state/market/risk pool combination, the total inflows to the system by definition will be equal to the total outflows from the system. For ease of understanding, hereafter we will refer to a state/market/risk pool combination as being a "risk-adjustment cell." As such, a given issuer's risk-adjustment payable or receivable for a given risk-adjustment cell will be dependent not just on the risk scores of their insured enrollees, but also on the risk scores of all other issuers with enrollees in that risk-adjustment cell. The regulations call for carriers to be notified of risk-adjustment settlements by June 30 of the year following the applicable benefit year (e.g., June 30, 2015, for the 2014 coverage year).

[3] Somewhat similar premium stabilization programs have existed for the Medicare Advantage and Medicare Part D lines of business since 2006.

States have the right to operate their own risk-adjustment program, but if they choose not to, the federal government will manage the risk-adjustment program for those states. As of Feb. 25, 2013, the only state known to be operating its own risk-adjustment program in 2014 was Massachusetts. For the federal program, the regulations indicate risk adjustment will be performed with concurrent data applied retrospectively, using demographic and diagnosis information in a benefit year to predict total plan liability for that benefit year. The regulations also indicate that a distributed-data environment will be employed, in which each issuer maintains its own data in a standardized format and allows the organization managing the risk-adjustment program to install software performing risk-score calculations for the issuer's data.

The magnitude and direction of the risk-adjustment settlement is dependent on the relative measured risk of the issuer's enrollees compared to all enrollees in the market (and implicitly dependent on the completeness and accuracy of the captured diagnosis data). The magnitude measured as a percentage of premium would be expected to be less for an issuer that had significant market share than for issuers with limited market share. But for either issuer, the settlement could be material in relationship to the expected profit margin for the line of business.

As a simplified example,[4] consider a risk-adjustment cell with only two issuers—Issuer A with 90 percent market share and Issuer B with 10 percent market share. Further, the two issuers charge identical premiums for the same cohort of enrollees, and Issuer A has an aggregate raw risk score of 1.0 while Issuer B has an aggregate raw risk score of 1.25.[5] In this example, Issuer A would be transferring 2.4 percent of its premium revenue to Issuer B as follows:

Aggregate risk score for cell = 0.9 * 1.0 + 0.1 * 1.25 = 1.025
Normalized relative risk score for Issuer A = 1.0 / 1.025 = 0.976
Transfer from Issuer A, as a percent of premium = 1.0 – 0.976 = 2.4 percent

This transfer would represent almost 22 percent of Issuer B's collected premium as follows:

Normalized relative risk score for Issuer B = 1.25 / 1.025 = 1.219
Transfer to Issuer B, as a percent of premium = 1.219 – 1.0 = 21.9 percent

Failure of either issuer to appropriately reflect risk adjustment in their financial statements could significantly change a user's view of financial performance.

Many have drawn parallels between the proposed ACA individual and small-group risk-adjustment mechanism and the risk-adjustment mechanism that has been in place for Medicare Advantage for a number of years. However, there are a number of significant differences between the two programs, including:

- Medicare Advantage risk adjustment is based on a retrospective model, in which demographic and diagnosis information from the prior calendar year is used to develop risk scores for the current calendar year. The retrospective model allows for most of the

[4] In actuality, factors such as metal level (platinum vs. gold vs. silver vs. bronze) and demographics (infant vs. child vs. adult) will impact the calculation of risk-adjustment transfers within a particular risk-adjustment cell.

[5] A difference of this magnitude in aggregate risk scores between carriers may be unlikely, but it is possible. For example, Issuer B could be a small Health Maintenance Organization (HMO) owned by a teaching hospital, while Issuer A could be a large company with a broad network and that historically performed significant underwriting.

input for the risk-adjustment mechanism to be known prior to the close of the calendar year, a characteristic not shared by a concurrent risk-adjustment model. Even so, there have been instances in which material modifications to the Medicare Advantage risk-adjustment payments have occurred in the year following the close of the benefit year, resulting in financial statement entries in a given calendar year that pertain to previous benefit years. The retrospective model also allows for interim risk-adjustment payments within the benefit year, while a concurrent model likely will have no payment transfers occur until final settlement.

- Medicare Advantage risk adjustment is performed as a single national program, instead of multiple programs based on state/market/risk pool combinations. Consequently, the complexity involved in estimating Medicare Advantage risk-adjustment amounts is somewhat less than it would be if the program operated on a more granular level.

- With many Medicare Advantage plans, the issuer expects to have a relatively high level of stability in membership from year to year; the primary reasons for membership changes are initial attainment of age 65 and death. In the commercial individual and small-group markets, by contrast, there is a greater likelihood of membership migration between markets (including the large-group and Medicaid markets) and/or between states. Instability in membership limits the ability to estimate risk-adjustment amounts accurately.

- For the Medicare Advantage program, the vast majority of enrollees are administered by the federal government. Their risk scores can be calculated precisely and payments based on prior diagnosis information, subsequently adjusted on a predetermined schedule using updated diagnosis information. As such, an issuer can assume that any payment adjustments subsequent to the benefit year will be based on the difference between final diagnosis information and what the issuer was paid based on the preliminary risk score calculation. This has allowed issuers to develop relatively accurate estimates of the ultimate risk-adjustment settlement.

Similarly, there are some parallels between the proposed ACA risk-adjustment mechanism and the risk-adjustment programs that some states adopted for Medicaid previously. Medicaid risk-adjustment programs typically are designed to be budget neutral to the state, and each issuer's risk score needs to be normalized relative to those of other issuers. However, typically the Medicaid risk scores are calculated using concurrent data applied, not retrospectively to adjust the current year's capitation rates, but prospectively to adjust the following year's capitation rates.

The ACA risk-adjustment mechanism has several elements that may lead to increased uncertainty in an issuer's reported financial statements, particularly with respect to 2014 financial reporting. These include:

- *Uncertainty as to the issuer's risk score*. With the risk-adjustment mechanism being based on concurrent analysis, as of year-end, the issuer does not possess all of the data that ultimately will be relevant to calculating its own risk score. Encounter reporting as of year-end will be substantially incomplete, as much will be unknown in terms of October, November, and December encounters. As such, the issuer's estimate at year-end of its

aggregate risk score systematically will be understated if it were to rely solely on the encounter data in its possession as of year-end.[6]

To rectify this, the issuer might seek to estimate, as of year-end, the extent to which its enrollees' incurred but not paid (IBNP) claims in time will translate to increases in the enrollees' risk scores. This is a substantially more complicated exercise than simply estimating the issuer's unpaid claim liabilities. To estimate aggregate unpaid claim liabilities, one only needs to work with total claim dollars for a given population, which may span multiple risk-adjustment cells. To estimate the impact of IBNP claims on the aggregate risk score, however, one would need to project specific distributions by diagnosis and severity of conditions at the risk-adjustment cell level. In short, new methodologies would need to be developed for this task. In any situation in which new methodologies are employed, substantial uncertainty exists around the validity of the arising estimates, until the models can be tested and calibrated.

Alternatively, the issuer might conclude that it cannot reliably estimate the risk score improvement attributable to IBNP claims, and instead base its year-end risk-adjustment estimate solely on the risk scores derived from claims already paid. In that case, the issuer systematically would expect to see favorable development in its risk-adjustment estimate in the successive calendar year, as the estimate is trued up to reflect the improvement in risk scores arising from claims paid after year-end. This would lead to positive net income in 2015 financial statements, but the direction and magnitude of the effect on net income for later years is less certain.

- *Uncertainty as to other issuers' risk scores*. This is perhaps the largest uncertainty. Even if an issuer had perfect knowledge of its own aggregate risk score for a particular risk-adjustment cell, the ultimate payment it makes or receives for that cell is dependent not on its absolute aggregate risk score, but on the relative relationship between its aggregate risk score and those of all issuers participating in that risk-adjustment cell. As such, in estimating its year-end risk-adjustment liability or asset, the issuer will need to take a position as to what it thinks the aggregate risk score is across the entire risk-adjustment cell. In some states, issuers may be asked by state regulators to provide data prior to the close of the benefit year that can be analyzed for the purpose of understanding each issuer's relationship to the aggregate risk of the market, or they may voluntarily contract with a third party to provide data for the same purpose. However, even with such an information sharing effort, changes by one issuer in information reported or how information is classified can impact significantly the risk-adjustment estimates for all issuers. Alternatively, some issuers are considering using population data by condition incidence to supplement their understanding of their relative risk profiles.

  This uncertainty will be greater in 2014 than in subsequent periods because after 2014, carriers will have an understanding of what the aggregate risk score is for each risk-adjustment cell based on the prior year's reported data. Since enrollees will become eligible for risk adjustment at different times throughout 2014 based on their policy

[6] Note that, as a matter of definition, additional encounter data can only increase an enrollee's risk score, never decrease it.

renewal dates, the estimation process for 2015 also may be complex, albeit not as complex as 2014.

- *Uncertainty as to member exposure*. There has always been some uncertainty at year-end around the issuer's membership, due to premium grace period provisions that customers may exercise after year-end that keeps their coverage inforce. However, the ACA could increase the uncertainty around estimating the issuer's member exposure, since it requires that issuers extend the grace period from 30 days (per typical historical practice) to 90 days for any member receiving a premium subsidy via the exchanges. As such, it becomes less clear at year-end which of the issuer's members have remained through the entire year. In turn, this can affect estimates relating to risk adjustment.

- *Granularity of the calculation*. The commercial risk-adjustment mechanism, as contrasted with the existing Medicare Advantage risk-adjustment mechanism, is not a single national calculation but rather a series of separate calculations for each risk-adjustment cell. Even an issuer operating in only one state likely will have at least three risk-adjustment cells to evaluate, namely individual catastrophic, other individual, and small group (as well as multiple metal-level models included within a cell's calculation). A larger holding company with multi-state operations and/or multiple legal entities will have significantly more cells to track. This level of granularity will complicate the modeling required to perform effective estimates of commercial risk-adjustment balances.

- *Implications of data reviews*. Although the data supporting the risk scores is maintained by each issuer, the regulations call for a data validation review that could lead to payment adjustments. The current regulations are proposing that no payment adjustments be made in 2014 or 2015. However, given the closed-pool nature of the risk-adjustment mechanism, it is unlikely issuers would agree to allow risk transfers based on data that was demonstrated subsequently to be erroneous to occur without adjustment. As such, there will be some level of increased uncertainty around potential adjustments in 2014 and 2015, and significant uncertainty in subsequent periods as a result of data validation reviews.

The regulations specify no interaction between the risk-adjustment mechanism and the reinsurance mechanism (discussed in Section I.B below). The risk-adjustment mechanism will be settled prior to the risk corridors and the calculation of any minimum loss ratio liability. As such, these other programs will not contribute to the uncertainty related to the risk-adjustment program.

B. Reinsurance Benefits

Starting in 2014, issuers offering products in the individual market can no longer deny coverage based on preexisting conditions. As a result, in 2014 the individual risk pool is expected to include a greater proportion of people with chronic conditions, resulting in increased incidence of large claims. The transitional reinsurance mechanism is designed to protect issuers in the individual market from this expected increase in large claims. The reinsurance protection is funded by assessments from the commercial health insurance market and from sponsors of self-funded health benefit plans (discussed further in Section II.B below). This funding is scheduled

to decrease systematically from 2014 through 2016 and be eliminated in 2017. Reinsurance benefits could be paid out of the funding through 2018 to the extent the funds collected through 2016 are not exhausted by 2016.

The reinsurance benefits are scheduled to be settled by June 30 of the year following the applicable benefit year. The regulations stipulate that the 2014 reinsurance benefits will be 80 percent of claims between $60,000 and $250,000 for a given individual, with no reinsurance benefit available for claims greater than $250,000.[7] HHS estimates the reinsurance benefits to result in individual premium reductions of 10 percent to 15 percent in 2014. The total dollars available for reinsurance benefits are targeted to be $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016.

There are a number of aspects of the reinsurance program that can increase uncertainty and/or impair comparability in the 2014 financial statements for an issuer. These include:

- *Accrual for reinsurance on unpaid claims*. With respect to excess-of-loss reinsurance, many issuers historically have accrued for reinsurance receivables on specifically identified claims only. However, the magnitude of the expected ACA reinsurance benefit in relationship to premium will motivate issuers to consider estimating the potential reinsurance recovery on unpaid claims for which no specific information is available, if permitted under the relevant accounting basis. This is somewhat complicated by differing payment patterns for large claims due to differences in claim submission processes and claim payment processes. As such, an accurate estimation of the reinsurance recovery on unpaid claims will not be as simple as applying a fixed percentage of overall unpaid claims. Many issuers have already needed to confront a similar estimation issue with respect to the Medicare Part D reinsurance program, and some of the techniques developed in that context may be transportable to this new context. To the extent issuers that historically have accrued reinsurance receivables only on identified claims do not change their accounting policies, the level of the reinsurance recoverable on unpaid claims will be of a magnitude that may make company-to-company comparability more difficult.

- *Magnitude of the reinsurance recovery accrual*. Since the regulations do not require interim settlements, an issuer will be recording an accrual at Dec. 31 for the full year's reinsurance recovery. For GAAP accounting, this probably will be a new receivable that potentially may be greater than the reported net income for the individual line of business. Under statutory accounting, reinsurance receivables relating to unpaid claims typically are recorded as an offset to unpaid claim liabilities, with only those reinsurance receivables relating to previously paid claims recorded as a separate asset. If the same accounting principles are applied to the new ACA reinsurance program, then a carrier's overall unpaid claim liabilities for the individual line of business, as reported on statutory financial statements, could be reduced noticeably. Under either accounting convention, the accrual will complicate any year-over-year comparability of financial statements for an issuer with significant participation in the individual market.

[7] One reason for this is so that the transitional reinsurance program does not "crowd out" the existing private reinsurance market, which typically involves attachment points of $250,000 or higher. However, the absence of protection for claims above $250,000 implies that the transitional reinsurance program will be less effective in mitigating financial statement volatility.

- *Potential valuation allowance on reinsurance recoverable*. Since reinsurance benefits are limited to available funds in the reinsurance pool, there is potential for reinsurance benefits to be reduced due to availability of funds. The reinsurance parameters (i.e., the 80 percent coinsurance, the $60,000 attachment point, and the $250,000 coverage limit) were set by HHS based on its modeling of not only expected individual market large claims, but also expected lives subject to the fixed per capita reinsurance contribution. If HHS has over-estimated the number of lives that will pay the reinsurance contribution, and/or under-estimated the number of individual market large claims, then the amounts collected to fund the 2014 reinsurance program may prove to be insufficient to pay out benefits in full. As such, each issuer will need to consider whether the reinsurance program will have sufficient funding to fully pay out reinsurance benefits according to the published parameters. To the extent that an issuer believes there is a risk that payment in full will not be made, then the issuer may wish to reduce its reinsurance recoverable by a valuation allowance, reflecting its assessment of the risk that the recoverable computed according to the published program parameters will not be paid in full. There likely will be a wide variety of models at Dec. 31, 2014 regarding assumptions around any reductions in reinsurance recoveries. This will complicate the company-to-company comparability across issuers with significant participation in the individual market.

- *Potential for denied reinsurance claims*. The review process for reinsurance claims may lead to some denial of filed claims. Since this review process will not occur until after the year-end financial statements are filed, the issuer either will have to estimate a probability of claim denial or accept the possibility that future income could be impacted adversely by any claim denial. Since there is no prior history for the ACA-specific reinsurance program, any estimates of the probability of a claim denial likely will vary significantly by issuers. Some issuers may conclude that they are unable to make such an estimate.

C. Risk Corridor

The risk-corridor program was designed to provide some aggregate protection against variability for issuers in the individual and small-group markets during the period 2014 through 2016. In many cases, the risk corridor will lessen much of the potential volatility and uncertainty in ultimate earnings that may be driven by the other two premium stabilization programs discussed above. The risk-corridor program pertains only to "qualified health plans" which includes products offered via the exchanges but also could include some off-exchange products.

The risk-corridor calculation is to be performed at a plan-specific level, which is far more granular than the level used to define risk-adjustment cells. The risk-corridor mechanism calls for payments from the issuer to HHS if actual experience is more than 3 percent below a target, and payments from HHS to the issuer if actual experience is more than 3 percent above the target. The amount of the payment is 50 percent of the amount between +/-3 percent of the target and +/-8 percent of the target and 80 percent of the amount that is +/-8 percent of the target. The risk corridor is to be settled by July 31 of the year following the applicable benefit year.

The risk-corridor calculation is to be performed after considering any amounts transferred to or from the issuer as a result of the risk-adjustment or reinsurance programs. Although the risk-corridor mechanism provides protection against extreme bounds of experience, there is a

substantial corridor in which all variance in experience directly affects the financial return to the company. In estimating the risk-corridor receivable or liability, it will be important that the company fully consider the expected impact of the risk-adjustment and reinsurance mechanisms. Failure to have a consistent and comprehensive model may result in large differences between projected settlements and actual settlements.

The estimation of the risk-corridor liability will be a relatively complex calculation at a finer level of granularity than the level at which most other reporting is made. However, the complexity of the risk-corridor calculation has been mitigated somewhat under an interim final rule promulgated in March 2013, which states that the claims costs used in a particular plan's risk-corridor calculation should not be specific to that plan, but instead should represent a pro rata allocation of the issuer's overall claim costs for the plan's state/market cell.

Due to the asymmetrical nature of the risk-corridor calculation, an overstatement of expense in one cell offset by an understatement of expense in another cell does not necessarily result in zero financial impact; for example, if the overstatement is in the 80 percent corridor while the understatement is in the 0 percent corridor, the financial impact would be 80 percent of the differential. In light of the use of allocated state/market results in risk-corridor calculations rather than plan-specific results, however, the likelihood that an issuer would have some plans in the 0 percent corridor and others in the 80 percent corridor becomes significantly diminished.

Section II – New Taxes and Fees

The ACA creates a number of new taxes and fees that will be levied in the future on health insurance issuers (and sometimes on sponsors of self-funded benefit plans). Two of these new expenses, in particular, may be material to issuers' financial statements in the near future—the new non-deductible excise tax assessed to issuers under ACA Section 9010 and the contributions made by issuers (and also self-funded benefit plan sponsors) to fund the reinsurance benefits discussed in Section I.B above.

A. Health Insurance Providers Fee

Under the ACA, starting in 2014, any company that writes certain types of health insurance on U.S. risks will be subject to a new excise tax, which is referred to in proposed regulations as the HIP fee.

The HIP fee will be assessed on an annual basis, with the first payment due by Sept. 30, 2014. Companies active in the health insurance market will receive a bill from the federal government based on market share as measured using the previous year's amount of premiums in eligible lines of business. However, there are a few adjustments to premiums in the HIP fee calculation, and the most notable is that a company not subject to federal income tax only counts one-half of its premiums in the calculation. Under the proposed regulations, eligible lines of business appear to include insured major medical, dental/vision, Medicare Advantage, Medicare Part D, and Medicaid. It excludes stop-loss, self-funded products, Medicare Supplement, disability, long-term care, specified disease, and accident products. The statute specifies the total amounts to be collected from the industry in each year, starting with $8.0 billion for 2014, increasing to $11.3 billion for both 2015 and 2016, and then increasing again beyond 2016. Federal regulators will use premium reporting from the prior year to issue a set of bills to companies that sum exactly to

the statutory level of fees to be collected from the industry. In this regard, the HIP fee assessment mechanism has strong similarities to mechanisms that exist today in some states (e.g., Texas, Illinois) for the assessment of fees to fund state high-risk pools—an aggregate dollar amount established by regulators is apportioned to issuers in proportion to prior year premium market share.

In situations in which premium market share information for 2013 is used to determine the amount of an assessment that an issuer will be required to pay in 2014, normal practice under both GAAP (see AICPA SOP 97-3) and statutory accounting is for the issuer to accrue its estimate of the assessment due in 2014 as a liability in its year-end 2013 financial statements. However, in the case of the HIP fee, a different treatment has been adopted for both GAAP and statutory accounting. Under the GAAP treatment (see FASB ASU 2011-06), the issuer would recognize the liability for the first time on Jan. 1, 2014, at which point it would recognize its estimate of the full year's expected liability and simultaneously recognize an offsetting intangible asset. Over the course of 2014, the asset established at the beginning of the year would be amortized away, leading (assuming the accuracy of the original liability estimate) to ratable recognition in GAAP expense throughout 2014 of the HIP fee payable in 2014. In 2012, the NAIC adopted a statutory accounting treatment for 2013 that, if extended into 2014, would produce largely the same results as GAAP, with the added nuance that the intangible asset would be non-admitted. This implies that the issuer's statutory surplus in its first quarter 2014 statutory financial statements would be reduced by the issuer's estimate of the full year's HIP fee. However, as of this writing, the 2014 statutory accounting treatment remains under discussion. A proposal recently exposed for public comment by the NAIC would involve recognition of five years' worth of HIP fee payments (2014-2018) as expense over the course of four years' statutory financial statements (2014-2017), creating significant GAAP-Statutory Accounting Principles (SAP) differences in 2014-2016 followed by smaller GAAP-SAP differences in 2017 and beyond.

A discussion of how the HIP fee may influence premium pricing is necessary to understand the financial reporting implications.

The evolving industry practice has been to include the HIP fee in pricing for products sold or renewed in February 2013 and later, with the amount included being level over the 12-month contract period and reflective of the proportion of the policy period that intersects 2014. Under this approach, the amount to be included in monthly premiums for a 12-month contract issued in June 2013 would be five-twelfths of the amount to be included in monthly premiums for a 12-month contract issued in January 2014, since only five-twelfths of the coverage under the June 2013 contract lies within 2014. Some states allow this approach; others prefer an approach in which the HIP fee should not be included in premiums until 2014. Another potential approach is to dispense with level premiums over the 12-month policy period, and instead charge one premium for the portion of the policy year in 2013 and a higher premium, inclusive of a provision for the HIP fee, for the portion in 2014. However, there may be regulatory hurdles to such an approach. Further, it also could raise accounting issues: should revenue recognition be levelized over the policy year even if premiums will be charged in a non-level fashion?

With this as background, the existence of the HIP fee raises a number of issues regarding issuers' financial statements and metrics used by financial analysts:

- *Expense estimation risk*. Issuers' interim financial statements, particularly in 2014, could materially misestimate the HIP fee amount. By the time March 31, 2014, financial statements are prepared, an issuer will know its own 2013 premiums and may be able to derive some reasonable estimate of industry wide 2013 premiums (e.g., by subscribing to data sources that compile issuers' year-end statutory financial statements) in order to develop its estimate of what portion it will need to bear of the total $8 billion fee. This industry level estimation is made more challenging by 1) the need to identify those companies that are allowed to discount the amount of premium included in the calculation, and 2) that existing public financial statements may not delineate between premiums subject to the HIP fee and those premiums not subject to the fee. As such, with no prior year calculation to serve as a guide, there will be some uncertainty in even the most sophisticated issuer's estimate. That uncertainty could manifest itself during, for example, the third quarter 2014 via a need to recognize more, or less, year-to-date HIP fee expense after the HIP fee bills have been issued and the actual full year exposure is known. As opposed to many of the other issues discussed in this paper, however, the HIP fee does not raise concerns about inter-year estimation risk, only intra-year estimation risk.

- *Earnings emergence implications of revenue/expense mismatch*. To the extent that the issuer does collect premiums in 2013 that are intended to prefund the HIP fee owed in 2014, the evolving accounting consensus appears to be that the issuer has no ability to defer the recognition of revenue from 2013 to 2014. To the extent that the associated expense is not being recognized until 2014, a mismatch exists so that many issuers will report material amounts of positive incremental net income in 2013 attributable to its HIP fee recoupment strategy. Potentially, that positive incremental net income in 2013 could be offset by negative incremental net income in 2014, to the extent that what the issuer collects in 2014 premiums related to the HIP fee is less than the associated 2014 outflows. As such, with respect to year-over-year earnings growth, the HIP fee creates an upward bias in 2013 and (depending on the precise details of the issuer's pricing strategy) could create a downward bias in 2014.

- *Comparability across issuers subject to different tax code provisions*. As noted above, the HIP fee is a non-deductible excise tax, and companies exempt from federal income tax receive preferential status in the calculation of the HIP fee owed. These differences related to tax status lead to differences in the impact of the HIP fee on the issuer's financial statement and metrics derived from there.

  To demonstrate this, below is a simple, hypothetical example involving three issuers: one exempt from federal income tax, a second that pays federal income taxes at the alternative minimum corporate rate of 20 percent (e.g., a Blue Cross Blue Shield organization benefiting from the special deduction found in Section 833(b) of the Internal Revenue Code), and a third that pays federal income taxes at the normal corporate rate of 35 percent. In the example, we presume that in absence of the HIP fee, each of the three issuers would have written $10,000 of premium priced to achieve an after-tax profit margin of 4.0 percent. We then assume that each dollar of premiums included in the market share calculation generates one-and-a-half cents of HIP fee liability for the issuer, and that each issuer will raise premiums as necessary to maintain the same amount of

expected after-tax profits after the introduction of the HIP fee as it would have had before the fee's introduction.

		Issuer's Income Tax Rate		
		0%	20%	35%
Premiums before HIP Fee recoupment		10,000	10,000	10,000
Premiums for HIP Fee recoupment		75	188	231
Total premiums		10,075	10,188	10,231
Claims		8,350	8,250	8,250
Expenses excluding HIP Fee		1,250	1,250	1,135
Health Insurance Providers Fee		75	150	150
Operating Income		400	538	696
Taxable Income		*NA*	*688*	*846*
Federal Income Tax		NA	138	296
Net Income		400	400	400
MBR before HIP Fee recoupment		83.5%	82.5%	82.5%
MBR after HIP Fee recoupment		82.9%	81.0%	80.6%
Effective Tax Rate		NA	25.6%	42.5%

Key observations from this example include the following:

- The required increment to premiums, expressed as a percentage of what the premiums otherwise would have been, varies from 0.75 percent for the tax-exempt issuer to 2.31 percent for the issuer taxed at 35 percent. These differences reflect two issues: first, the tax-exempt issuer's lower level of HIP fee per dollar of premium written, by statute, and second, the taxable issuers' need to gross up the HIP fee by the applicable income tax rate for the issuer to remain whole on an after-tax basis, due to the HIP fee having been defined as a non-deductible excise tax.

- The recoupment of the HIP fee in premiums leads to a decrease in the pure ratio of claims to premiums, which we refer to as the MBR.[8] Moreover, the magnitude of that decrease is more significant the higher the issuer's income tax rate.

- The ratio of income taxes to operating income, which in the table is referred to as the effective tax rate, materially exceeds the statutory tax rate. This is attributed to the fact that the issuer now has a non-deductible expense, namely the HIP fee, that is significant in relation to operating income.

- *Customer rebate implications of revenue/expense mismatch*. The example above did not consider the rebates owed by issuers to their customers under the ACA in situations in which a federally defined medical loss ratio (MLR) exceeds a given threshold.

[8] We use the term MBR to distinguish this metric from the medical loss ratio (MLR) defined in federal regulation for purpose of calculating customer rebates, which we discuss below.

Federal taxes and fees are adjustments to the denominator of the ACA's MLR metric. Therefore, if the incremental premiums collected by an issuer in a given year are equal to the incremental HIP fee expense and associated incremental federal income taxes recognized by that issuer in that year's federal MLR reporting, then there is no net impact on the MLR or on the denominator and, hence, no net impact on rebates. However, if incremental premiums for a year exceed that year's incremental recognized tax expense, which is likely to occur in 2013, then the net effect is to increase the denominator, decrease the MLR, and potentially increase rebates to customers. Conversely, if incremental premiums for a year are less than the year's incremental recognized tax expense, which could occur for some issuers in 2014, then the net effect is to decrease the denominator, increase the MLR, and potentially decrease rebates to customers. As a result, the impact of customer rebates could lessen the swing in earnings from 2013 to 2014 as discussed earlier.

As discussed above, it is possible that statutory accounting may evolve in such a way that the amount of the HIP fee expense recognized in the statutory income statement in a given year differs materially from the amount of fee expense paid in that year. The implications that this might have on federal MLR reporting are unclear.

B. Reinsurance Contribution

As discussed in Section I.B, the ACA creates a transitional program providing reinsurance benefits to issuers operating in the individual market. These benefits will be funded by assessments charged to health insurance issuers operating in the group or individual markets and to sponsors of self-funded health plans. This payment was named the "reinsurance contribution" in federal regulation, although the terms "reinsurance fee" and "reinsurance assessment" also have been used. As contrasted with the HIP fee discussed above, regulations implementing the reinsurance contributions have already been finalized.

The reinsurance contribution will be assessed on an annual basis for calendar years 2014 through 2016 only. Federal regulators will announce the national reinsurance contribution rate, expressed in per-member-per-month (PMPM) terms, in advance of the applicable calendar year. For 2014, it was proposed in November 2012 and confirmed in March 2013 that the national reinsurance contribution rate would be $5.25 PMPM. In addition to the national reinsurance contribution rate, states have the ability to charge their own supplemental contribution rate to insured residents of that state to fund additional reinsurance benefits for the individual market in that state beyond the benefits funded by the national reinsurance contributions. The authors are not aware of any state that, for 2014, will exercise the option to charge a supplemental reinsurance contribution.

The regulations state that each contributing entity (meaning a health insurance issuer or self-funded plan sponsor) will submit membership data spanning only the first nine months of the calendar year to federal regulators in November. Most observers think that the entity's reinsurance contribution liability for the calendar year will be determined by taking the submitted membership data, annualizing it (e.g., multiplying the member months for the first nine months of the year by a factor of twelve-ninths), and multiplying by the announced PMPM contribution rate. Via this process, bills will be sent to entities in December, and the sum of those

bills generally will be unequal to the statutory funding target for aggregate reinsurance contributions ($12 billion in 2014, $8 billion in 2015, and $5 billion in 2016). This reflects the reality that actual industry-wide enrollment will not match the industry-wide enrollment assumption used previously to set the PMPM contribution rate. A different interpretation could be that the regulators will use the enrollment data submitted in November to retroactively change the contribution rate for that year, thus producing a set of bills in December that exactly matches the statutory funding target.[9]

As discussed above with the HIP fee, health insurance issuers are expected to attempt to recoup the reinsurance contribution by incorporating it into the pricing of those products whose enrollees are subject to the assessment. The magnitude of the issuer's 2014 reinsurance liability will be based on its membership over the period January 2014 through September 2014. This will be the same for future years (in particular, note that membership figures from the fourth quarter are never used). As such, the issues surrounding the inclusion of the reinsurance contribution in pricing for products sold or renewed in February 2013 and later are similar to issues discussed above involving the HIP fee.

There are three key differences, however, between the reinsurance contribution and the HIP fee. First, there is in some sense a more exact and direct relationship between the reinsurance contribution and a particular enrollee than between the HIP fee and that enrollee. Earlier, we analogized the HIP fee to existing state high-risk pool assessments. Continuing that analogy, the reinsurance contribution can be viewed as being conceptually similar to existing state premium taxes, albeit calculated on a per capita rather than percent-of-premium basis. This difference could influence the attitudes of issuers and regulators, with respect to recoupment strategies and associated messaging. Second, there is far greater transparency available with respect to the magnitude of the reinsurance contribution. As already noted, regulators have stated that the 2014 rate will be $5.25 PMPM. Third, the reinsurance contribution is tax-deductible, so considerations related to the issuer's tax status are not relevant in this context, as contrasted with the HIP fee situation described above.

With this as background, the existence of the reinsurance contribution raises some of the same issues discussed above for the HIP fee, as well as some issues, regarding issuers' financial statements and metrics used by financial analysts:

- *Expense estimation risk*. As discussed above, the most common interpretation of the final regulation is that each year's national reinsurance contribution rate is fixed in advance, and the total amount of funding generated by that rate may end up differing from the statutory funding target. As such, then from an issuer standpoint, expense estimation risk relating to the reinsurance contribution is unlikely to be significant. However, if the final regulation is modified to allow an alternative interpretation, namely that regulators will reset the national contribution rate in December after the enrollment reports come in, then issuers will be exposed to estimation risk in their fourth quarter financial statements with respect to amounts recognized in the previous three quarters.

[9] See comments submitted in Dec. 2012 by the ERISA Industry Committee, available at http://www.eric.org/uploads/doc/health/ERIC%20Comment%20Letter%20on%20Transition%20Reinsurance%20Fee.pdf

- *Earnings emergence implications of revenue/expense mismatch*. Assume for the moment that the national reinsurance contribution rate is $5.25 PMPM for 2014 and $3.50 PMPM for 2015. Assume also that the issuer remains committed to level premiums across the policy year, and recoups in those level premiums the following amounts for the reinsurance contribution: $5.25 PMPM for customers whose policy year starts in January 2014; $3.50 PMPM for customers whose policy year starts in January 2015; steadily declining amounts between $5.25 PMPM and $3.50 PMPM for customers whose policy year starts between February 2014 and December 2014; and steadily increasing amounts between zero and $5.25 PMPM for customers whose policy year starts between February 2013 and December 2013. The total amount collected by the issuer should equal its aggregate reinsurance contribution expense (excluding, for simplicity, issues such as lapses and incremental premium taxes). If looking at 2014 in isolation, however, the issuer is paying out $5.25 PMPM for every member, but collecting less than $5.25 PMPM for every member except those whose policy year started in January 2014. Therefore, this issuer can be expected to have negative 2014 earnings associated with the reinsurance contribution, offset by positive earnings in 2013 and in years beyond 2014. As such, the earnings emergence timing issues associated with the reinsurance contribution are similar to those discussed above for the HIP fee.

- *Comparability across issuers subject to different tax code provisions*. This issue is not relevant to the reinsurance contribution, unlike the HIP fee. For all issuers, however, note that efforts to recoup the reinsurance contribution via premiums will cause a decrease in the MBR, similar to what was shown above in the numerical example for the HIP fee.

- *Customer rebate implications of revenue/expense mismatch*. This issue is largely the same for the reinsurance contribution as it is for the HIP fee. Under the final regulations, similar to the HIP fee, the issuer's payment of reinsurance contributions is a negative adjustment to the denominator (this was a change from the proposed regulations, in which the issuer's payment of reinsurance contributions would have been a positive adjustment to the MLR numerator, rather than a negative adjustment to the MLR denominator[10]).

- *Cash flow timing*. Under the regulations, issuers will receive the annual reinsurance contribution in mid-December and will have 30 days to pay the bill. This proposed timing gives the issuer discretion over whether the cash payment of the reinsurance contribution will occur in the same year as the expense is recognized in the issuer's income statement or in the subsequent year. As such, the relationship between an issuer's cash flow from operations and its operating earnings for the calendar year could be impacted materially by whether the issuer chooses to pay the reinsurance contribution bill in December or in January.

- *Administration of self-funded business*. Self-funded plan sponsors also are liable for reinsurance contributions. To the extent that those plan sponsors employ health insurance

[10] The Academy's Medical Loss Ratio Subgroup submitted a comment letter to HHS, advocating for the change that was ultimately adopted, wherein reinsurance contributions would be treated as regulatory fees subtracted from the MLR denominator. See http://www.actuary.org/files/Acad_comments_MLR_123112.pdf.

issuers as benefit administrators, a sponsor may ask an issuer to get involved in the process of remitting the sponsor's reinsurance contribution to regulators. However, in this situation, an issuer would not recognize any income statement items related to serving as a payment conduit for its self-funded customers. If a self-funded customer wished to prefund its reinsurance contribution liability by making monthly estimated payments to the issuer, rather than waiting to pay the annual bill in one lump sum, then the issuer's balance sheet could be grossed up (i.e., an asset for funds held on deposit with an equal and offsetting liability).

C. *Other New Fees*

In addition to the HIP fee and the reinsurance contributions, there are other new ACA-related taxes and fees that will apply to health insurance issuers in the near future. Each of these fees are mentioned below for completeness, although in general they do not generate as many significant issues from a financial reporting perspective as the two items previously discussed at length.

- The *Patient Centered Outcomes Research Institute (PCORI) fee* is a per-member federal tax that applies to plan years ending between Oct. 1, 2012, and Sept. 30, 2019. The magnitude of the PCORI fee is very small—$1 PMPY for the first plan year, and $2 PMPY for the second, with successive increases commensurate with inflation.

- The *risk adjustment user fee* is a per-member fee that will apply to issuers of plans to which the ACA risk-adjustment program applies. It is intended to fund the administrative costs of the risk-adjustment program. The magnitude of this is also small—for 2014, the fee has been set at $0.96 PMPY.

- The *federally facilitated exchange (FFE) user fee* will apply to issuers of plans offered through a federally facilitated exchange. Similar fees may apply to issuers of plans offered through state-operated exchanges. For 2014, the FFE user fee has been set at 3.5 percent of premium, which may make it the largest in magnitude of the various ACA-related taxes and fees. A recently proposed regulation on preventive services created conditions under which an issuer may be entitled to credits against its FFE user fees.[11]

  Recent regulations have clarified that, from a pricing standpoint, the FFE user fee needs to be pooled across the issuer's exchange and off-exchange business, even though the expense itself is incurred only with respect to exchange premiums. As such, while an issuer faces little estimation risk with respect to the FFE user fee expense itself (apart from the issue noted above regarding potential credits), an issuer may be exposed to estimation risk as it prices for the FFE user fee expense as it makes an assumption regarding , the mix of business on and off-exchange.

[11] These credits relate to situations in which the issuer (or an affiliate) administers benefits for a self-funded plan sponsor that qualifies for a religious exemption to the usual ACA requirement that contraceptive benefits be covered. In that situation, under the proposed regulations the contraceptive benefits for that sponsor's enrollees are to be covered under special insurance policies, for which the issuer cannot collect any premium but receives FFE user fee credits corresponding to the claims incurred under these policies. For further discussion of the potential MLR implications of this situation, see the Academy's MLR Regulation Work Group's comment letter to HHS, at: http://www.actuary.org/files/Academy_letter_on_MLR_and_preventive_coverage_032813.pdf.

Section III – Advanced Payments

The ACA creates new programs under which health insurance issuers will receive from regulatory agencies advance payments that may require subsequent true-ups. Although similar situations exist today, their prevalence will increase dramatically under the ACA. Some financial reporting considerations related to these new forms of advanced payments are discussed below.

A. Premium Subsidies

The ACA creates premium subsidies in the form of tax credits, paid in advance of tax filing and paid directly to health insurance issuers whose members have income of 100 percent to 400 percent of the federal poverty level (FPL). Conceptually, this resembles the Health Coverage Tax Credit (HCTC) created under the Trade Act of 2002. However, the scope and magnitude of the ACA's new premium subsidies far exceeds that of the existing HCTC premium subsidies.

Some of the premium subsidy payments made to issuers likely will be on behalf of members who are no longer enrolled with the issuer, due to having lapsed coverage without notifying the issuer or the exchange. The availability of a 90-day grace period for these members will make it more difficult to determine if a member continues to be in force. The issuer will need to make an estimate of the portion of advanced payment tax credits it has received from the exchange for members who may no longer be in force, and establish a liability for the amount that will need to be refunded to the government.

Alternatively, depending on the timeliness with which the exchange and the government pay the issuer for the advance payment tax credits applicable to its members, a receivable for these outstanding receipts may need to be set up.

B. Cost-Sharing Reduction Payments

The ACA requires that issuers make available cost-sharing reduction (CSR) silver plan versions that have reduced cost-sharing amounts on essential health benefits for enrollees who have household income of 250 percent of FPL or less. These plans result in lower out-of-pocket costs for the eligible enrollee. The issuer is reimbursed by the federal government for the difference in cost-sharing amounts between these CSR plans and the standard silver plan. This is done via monthly estimated payments from the federal government to the issuer, with a true-up to occur each year.

If the government paid too much in estimated payments to the issuer, the issuer will need to reimburse the government for the overpayment, and vice versa. This potential mismatch between the advanced CSR payments and the annual true-up will require the issuer to set up an asset or liability to account for these differences. For known claims, this can be an exact calculation; however, the issuer may need to consider how to handle incurred but unpaid claims.

The subsidization of cost sharing under the ACA has strong similarities to the Medicare Part D low-income cost-sharing (LICS) subsidy program. Under NAIC interpretation 05-05 for statutory accounting, a health insurance issuer does not recognize any income statement items relating to the Part D LICS program. Our understanding of industry practice is that issuers

typically follow the same practice in their GAAP accounting. Similar logic may apply to the ACA's CSR program.

Section IV – Existing Actuarial Liabilities

Earlier sections of this white paper have focused on items that will be new to a health insurance issuer's financial statements as a result of the ACA's 2014 market reforms. In the remainder of this paper, we discuss the impact that these same market reforms are expected to have on the issuer's existing types of actuarial liabilities.

A. Claim Liabilities

Typically, health insurance issuers calculate unpaid claim liabilities by analyzing historical payment patterns for a block of business using completion factors, coupled for the most recent months with a PMPM or loss ratio approach taking into account trend, seasonality, large claims, inventory, and other operational factors. With changes from the ACA, however, this approach may be more challenging.

There will be considerable uncertainty around the morbidity level of issuers' insured members in 2014. An issuer's risk pool in a market will change with the introduction of health benefit exchanges, as a significant portion of the individual and/or small-group market likely will come from the previously uninsured population and/or from those previously enrolled in high-risk pools. For issuers active in multiple markets, shifts in membership can be expected across markets—individual, small group, large group, Medicare Advantage, and Medicaid. In light of this, issuers will need to use marketplace modeling to project the PMPM for recent months in 2014. They will not be able to rely on pre-2014 experience trended forward due to the substantial change in mix. Morbidity after Jan. 1, 2014, will be different from historical morbidity due to the change in mix of members who also may use coverage differently than past members.

Plan designs also will be changing significantly in 2014. Monitoring the mix of plans has always been a consideration in determining the claim liability, and this will become more important in 2014. The average benefit level for blocks of individual business likely will be higher in 2014 than in the past due to minimum actuarial value and essential health benefit requirements. The opposite could occur for blocks of group business, with silver plans becoming the de facto benchmark. Issuers will need to evaluate whether to combine on-exchange and off-exchange plans. They also will need to evaluate whether to combine exchange plans across metal levels, for reserving purposes, to the extent that completion factors and seasonality are expected to be materially different. Issuers will need to take into account benefit design changes and the impact that new low-income cost-sharing subsidies will have on seasonality patterns.

Increased provider risk sharing also will have an impact on claims reserves. Issuers will have to decide if they will calculate reserves separately for Accountable Care Organizations (ACOs) or combine them with commercial business. If they are combined, the PMPM membership base becomes an issue. With risk-sharing, issuers will have to determine provider incentive liabilities for amounts owed to providers under gain sharing. If claims are higher than targets, issuers will need to determine if they are going to set up a receivable from the providers or cut off claim payments. Provider solvency becomes an issue and will need to be part of the calculation.

Consideration will need to be given to margin/provision for adverse deviation (PAD) amounts since these liabilities are not like medical claims.

In periods during which an issuer's risk pool changes significantly (e.g., first quarter 2014), claim liability estimates are based more on pricing assumptions and judgment rather than definitive data on morbidity of new entrants. As such, it is expected that there will be greater potential for intra-year prior period reserve development (adverse and/or favorable) in periods immediately subsequent to large changes in risk pool (e.g., second quarter 2014). As the nature of risk pool stabilizes, the potential for reserve development should diminish to historically normal levels. Note that the impact of prior period reserve development on financial statements may be muted by partially offsetting entries to risk corridor and MLR rebate amounts.

Payment patterns also are likely to be impacted by claims operations. Health issuers will need to monitor claims inventories. This will be exacerbated by the implementation of ICD-10, currently slated for October 2014. This transition is expected to lead to greater volumes of pended claims and a lengthening of lag times due to coding errors and questions. This will further add to the volatility in 2014 and will prolong the transition to a new steady state in claims lag patterns.

B. Contract Reserves

Some issuers have held contract reserves (i.e., policy reserves, benefit reserves, or active life reserves) in the individual market to reflect the extent to which a portion of past premiums was designed to prefund future claims. In a few cases, this prefunding was a consequence of an issue age, rather than attained age, premium structure. More commonly, however, this prefunding went hand-in-hand with medical underwriting and renewal pricing practices, in which the issuer expected that policyholders in early policy durations would have lower medical benefit ratios than policyholders in later policy durations. This type of reserve appears to be far less relevant with respect to new policies written in 2014 and later, since medical underwriting will no longer be allowed. However, some issuers may consider holding a small contract reserve under the theory that claims will be higher in the second year for new entrants to the individual market, as those individuals become familiar with provider networks and higher-deductible plans.

For pre-2014 individual policies, issues arise about how to handle contract reserves currently being held. For GAAP, to the extent that the lock-in principle is applied, it may not be possible for issuers to update their contract reserve assumptions to reflect the fact the future expected lapse rates now differ greatly from original assumptions (e.g., as individuals move from closed blocks to new exchange products).[12] In that case, we would expect to see large changes in reserve balances and Deferred Acquisition Costs (DAC) balances when the excess lapses actually occur. With respect to significant lapses expected to occur on Jan. 1, 2014, the issuer may have an option whether to recognize those lapses in the Dec. 31, 2013, reserve calculation. For SAP, the lock-in principle generally is believed to not apply. Therefore, some issuers already may have been making changes to their future lapse assumptions in their 2011 and 2012 reserve calculations, reducing the potential for a large impact on reserves when the excess lapses materialize.

[12] Situations may exist in practice in which the issuer is not applying the lock-in principle to the GAAP contract reserves (e.g., when the SAP reserves are being continuously unlocked and the issuer wants to avoid having GAAP-SAP differences in the reserves), but the deviation from GAAP is not judged to be material to the financial statements.

Since the change in contract reserves is one piece of the MLR rebate calculation, the release of contract reserves will have an impact on the magnitude of customer rebates. However, there is some uncertainty as to whether the future release of contract reserves that accrued prior to the inception of rebate requirements in 2011 should be allowed to impact future years' MLR calculations. Similarly, some ambiguity may exist over how a change in policy reserves arising from a change in methodology or from the unlocking of previous assumptions should be handled within the MLR calculation.

C. Due and Unpaid Premium Asset

As mentioned in Sections I.A and III.A, under the ACA, exchange members receiving premium subsidies will have a 90-day premium grace period, rather than the 30-day grace period used today. This will introduce a need for issuers to rethink their existing approach for estimating the due and unpaid premium asset.

D. Premium Deficiency Reserves

An issuer records a premium deficiency reserve (PDR) when it projects that future premiums for a block of business will be insufficient to cover, over some timeframe, future claims plus future expenses that are attributable directly to the block of business, or represent overhead allocated to the block that cannot be covered by profits from other blocks of business. In essence, a PDR leads to an acceleration of some expected future losses into the present.

Some of the issues discussed earlier in this paper can affect an issuer's PDR calculations. For example, if an issuer has over-estimated its risk adjustment receivable, then it also may have over-estimated future risk-adjusted premium revenues. As such, it may have under-estimated future period losses and the currently required PDR.

One of the main inputs into a PDR calculation involves the timing and magnitude of future rate increases. ASOP 42 implies that the rate increase assumptions used in a PDR calculation should take into account the issuer's expectations, in light of market conditions and regulatory restrictions. As such, a PDR model that assumes rates will increase by 15 percent in six months' time is appropriate only to the extent not only that management proposes such an increase, but also that the increase will not encounter any regulatory impediments. As such, with enhanced levels of rate review under the ACA, considering the likelihood of regulatory approval becomes even more important when evaluating appropriate rate increase assumptions for PDR calculation purposes. Viewed differently, the likelihood that the issuer's PDR estimate will, with hindsight, prove to have been "wrong" is now heightened by the additional uncertainty, attributable to the enhanced rate review process, regarding whether the magnitude and timing of actual future rate increases will match the assumptions made in the PDR model.

Another principal consideration in PDR calculations is the level of granularity at which the issuer's business is grouped into blocks for PDR testing purposes. Practice varies among issuers in this regard, as different issuers take different interpretations of the "marketed, measured and serviced" language found in the accounting literature. Conceivably, changes in the health insurance marketplace beginning in 2014 could lead to changes in how issuers define their

blocks of business for PDR testing purposes. Exchange products and off-exchange products may, or may not, be considered to constitute different blocks of business for PDR purposes.

As discussed above, users of issuers financial statements need to be aware of the many changes in 2014. They will need to take these into account as they look at trends and comparability from period-to-period and between issuers.