American Academy of Actuaries
ISSUE BRIEF
NOVEMBER 2013

Key Points

There are several Affordable Care Act provisions that may affect health insurance issuers' financial reporting, including the premium stabilization programs (i.e. risk adjustment, reinsurance, and risk corridors), new taxes and fees, advance payments, and existing actuarial liabilities. These may have the following effects:

- Increased level of uncertainty in financial statements.
- Issues with year-to-year comparability of the balance sheet.
- Issues with year-to-year comparability of the income statement.
- Issues with issuer-to-issuer comparability.

Additional Resources

Financial Reporting Considerations Under the Affordable Care Act: http://actuary.org/files/HPFRC_White_Paper_on_ACA_and_FR_final_062513.pdf

Financial Reporting Implications Under the Affordable Care Act

As 2014 approaches, the market reforms introduced by the Affordable Care Act (ACA) may create uncertainty for health insurance issuers, especially around the risk that actual customer behavior in the reformed market will deviate from expectations made by issuers in their pricing. But another ACA element has received comparatively less attention: the additional volatility that may exist in upcoming financial statements due to increased actuarial estimates in financial reporting. The American Academy of Actuaries' Health Practice Financial Reporting Committee has developed this brief to provide an overview of those ACA provisions that may affect health insurance issuers' financial reporting, including the premium stabilization programs (i.e., risk adjustment, reinsurance, and risk corridors), new taxes and fees, advance payments, and existing actuarial liabilities.

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.

American Academy of Actuaries
1850 M Street NW, Suite 300, Washington, DC 20036
Tel 202 223 8196, Fax 202 872 1948
www.actuary.org

Mary Downs, Executive Director
Charity Sack, Director of Communications
Craig Hanna, Director of Public Policy
Cori Uccello, Senior Health Fellow
Heather Jerbi, Assistant Director of Public Policy

- **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 or payables, risk-adjustment receivables or payables, and transitional risk corridors receivables or 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 Health Insurer Provider (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 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.

These are discussed below.[1]

Premium Stabilization Programs

A significant new driver of accounting uncertainty under the ACA is its set of premium-stabilization programs, which primarily will affect the commercial individual and small group lines of business starting in 2014.

Risk Adjustment

The new risk-adjustment program involves fund transfers from issuers whose pools of insured enrollees have lower-than-average risk scores to those whose pools have higher-than-average risk scores. This program is designed to allow a health insurance issuer to price individual and small-group products without consideration of the underlying relative health status of those purchasing these products. Issuers will no longer be able to employ traditional risk-management techniques, and 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 of the issuer's risk score.** As of year-end, the issuer will not possess all the data relevant to calculate its own

[1]For more detail on each of the items addressed in this issue brief, see the complete white paper, Financial Reporting Implications Under the Affordable Care Act, at http://actuary.org/files/HPFRC_White_Paper_on_ACA_and_FR_final_062513.pdf

The Academy Health Practice Financial Reporting Committee members are: Laurel A. Kastrup, MAAA, FSA, Chairperson; Rowen B. Bell, MAAA, FSA; Tim P. Deno, MAAA, FSA; Don Henson, MAAA, FSA; Earl L. Hoffman, MAAA, FSA; Darrell D. Knapp, MAAA, FSA; Jinn-Feng Lin, MAAA, FSA, FCA; Donna C. Novak, MAAA, ASA, FCA; James T. O'Connor, MAAA, FSA; Russell D. Willard, MAAA, FSA; D. Joeff Williams, MAAA, FSA

risk score. To rectify this, the issuer might seek to estimate the extent to which its enrollees' incurred but not-paid claims will translate to increases in the enrollees' risk scores.

- **Uncertainty as to other issuers' risk scores.** Even if an issuer had perfect knowledge of its own aggregate risk score for a particular market, the ultimate payment it makes or receives for that market is dependent on the relative relationship between its aggregate risk score and those of all issuers participating in that market.
- **Uncertainty as to member exposure.** The ACA could increase the uncertainty around estimating the issuer's member exposure, since it requires that issuers extend the grace period from the industry practice of 30 days to 90 days for any enrollee receiving a premium subsidy via the exchanges.
- **Granularity of the calculation**. The commercial risk-adjustment mechanism is not a single national calculation but rather a series of separate calculations for each market, which will complicate modeling 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 propose that no payment adjustments be made in 2014 or 2015.

Reinsurance

Additionally, the individual risk pool in 2014 is expected to include a greater proportion of people with chronic conditions, resulting in increased incidence of large claims. The ACA transitional reinsurance mechanism is designed to protect issuers in the individual market from this expected increase by providing reinsurance protection. The reinsurance protection is funded by assessments on the commercial health insurance market, and benefits are scheduled to be settled by June 30 of the following year.

Since the regulations do not call for interim settlements, an issuer will be recording an accrual at Dec. 31 for the full year's reinsurance recovery. The accrual will significantly complicate any year-over-year comparability of financial statements for an issuer with heavy participation in the individual market. Also, the reinsurance benefits are limited to available funds in the reinsurance pool, so there is potential for reinsurance benefits to be reduced due to availability of funds.

Risk Corridor

The risk-corridor program was designed to provide some aggregate protection against variability for issuers in the individual and small-group markets from 2014 through 2016. The mechanism calls for payments between the issuer to HHS if actual experience is substantially above or below targets, and payments slated to be settled by July 31 of the following year. While this provides protection against extreme bounds of experience, substantial variance in experience can directly affect the financial return to the company.

New Taxes and Fees

The ACA creates a number of new taxes and fees on health insurance issuers. Two in particular are likely to be particularly material to financial statements: the HIP fee and the contributions made by issuers to fund the reinsurance benefits.

HIP Fee

Starting in 2014, any company that writes certain types of health insurance on U.S. risks will

be subject to a new excise tax, the HIP fee, that is assessed annually. Health insurers 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.

The statute specifies the total amounts to be collected from the industry in each year, starting with $8 billion in 2014 and increasing over time. Federal regulators will use premium reporting from the prior year to issue a set of bills to companies that equal the statutory level of fees to be collected from the industry. Issuers' interim financial statements, particularly in 2014, could materially misestimate the ultimate HIP Fee amount. Additionally, as of this writing, the statutory treatment of the HIP fee is still under discussions regarding the recognition of 2015 HIP fee in financial statements. The GAAP and statutory treatment of the fees are currently different and may create confusion in how these fees are estimated and reported.

Transitional Reinsurance

The ACA also creates a transitional program providing reinsurance benefits to issuers operating in the individual market that will be funded by insurance issuers. Federal regulators will announce the national reinsurance-contribution rate in advance of the applicable calendar year, but the industry wide assumption rate might not match actual enrollment.

Advanced Payments

The ACA creates new programs under which regulatory agencies will make advance payments to health insurance issuers that may require subsequent true-ups. Premium subsidies in the form of tax credits will be paid directly to health insurance issuers whose members have incomes at the 100 percent to 400 percent of the federal poverty level (FPL). The issuer will need to estimate 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.

The ACA also requires that issuers make available cost-sharing reduction silver plan variations that have reduced cost-sharing amounts on essential health benefits for enrollees with household incomes of 250 percent or less of FPL. The issuer is reimbursed by the federal government for the difference in cost-sharing amounts between these Cost-sharing reduction (CSR) plans and the standard silver plan. 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 cost-sharing reduction payments and the annual true-up will require that the insurer set up an asset or liability to account for these differences.

Existing Actuarial Liabilities

Typically, health insurance issuers calculate unpaid claim liabilities by analyzing historical payment patterns for a block of business. 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 small-group market will likely come from the previously uninsured population or from those previously enrolled in high-risk pools. 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.

Increased provider risk sharing will also have an impact on claims reserves. Insurers will have to decide if they will calculate reserves separately for Accountable Care Organizations or combine them with commercial business. With risk sharing, insurers will have to determine provider incentive liabilities for amounts owed to provid-

ers 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.

When insurer's risk pool changes significantly, claim liability estimates are based more on pricing assumptions and judgment rather than hard data on morbidity of new entrants. So there will be greater potential for intra-year prior period reserve development in periods immediately subsequent to large changes in risk pool. As the nature of risk pool stabilizes, the potential for reserve development should diminish to historically normal levels.

Payment patterns also are likely to be impacted by claims operations. This will add further to the volatility in 2014 and will prolong the transition to a new steady state in claims-lag patterns.

Some issuers historically have held contract reserves in the individual market to reflect the extent to which a portion of past premiums was designed to prefund future claims. This type of reserve appears to be far less relevant with respect to new policies written in 2014 and later in the post-2014 individual market, since medical underwriting will no longer be employed. For pre-2014 individual policies, there are issues with how to handle contract reserves currently being held such as lapse assumptions post 2014.

An issuer records a premium deficiency reserve (PDR) when it projects that future premiums for some block of business will be insufficient to cover future claims plus future expenses that are either directly attributable to the block of business, or represent overhead allocated to the block that cannot be covered by profits from other blocks of business. A main input into a PDR calculation is the issuer's expectation on timing and magnitude of future rate increases. 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.

Conclusion

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.