Financial Reporting Implications Under the Affordable Care Act

Laurel A. Kastrup, MAAA, FSA
Chairperson, Health Practice Financial Reporting Committee

Darrell D. Knapp, MAAA, FSA
Member, Health Practice Financial Reporting Committee

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Agenda

- Background for the Health Practice Financial Reporting Committee (HPFRC) White Paper
- Premium Stabilization Programs
- New Taxes and Fees
- Advanced Payments
- Existing Actuarial Liabilities

Background for the HPFRC White Paper

Background

- In 2014, the ACA market reforms may create uncertainty for health issuers beyond changes that have occurred in the first three years of enactment
  - Customer behavior may differ from issuers projections with regard to pricing
  - Additional volatility for health insurance issuers due to increased need for actuarial estimates in financial reporting
- Considerations in the white paper based on final and proposed ACA related regulations issued through March 2013 and Generally Accepted Accounting Principles (GAAP) and statutory accounting guidance adopted as of that date (March 2013)

Possible Financial Reporting Effects Due to Provisions

- Increased level of uncertainty in financial statements
- Issues with year-to-year comparability of:
  - Balance sheet
  - Income statement
- Issues with issuer-to-issuer comparability

Premium Stabilization Programs

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Premium Stabilization Programs

- Risk Adjustment
- Reinsurance Benefits
- Risk Corridors

Risk Adjustment

- Designed to allow a health insurer to price and offer individual and small-group products without consideration of the underlying relative health status of individuals purchasing the products.
- Closed system at the state, market, and risk-pool levels
- States can operate their own risk-adjustment program
- 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

Risk Adjustment (cont.)

- Similar to risk-adjustment mechanism that has been in place in Medicare Advantage (MA), however, differences exist including:
  - MA 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 in the current calendar year
  - MA risk adjustment is performed as a single national program, instead of multiple programs based on state/market/risk pool combinations
  - With many MA plans, the issuer expects to have a high level of stability in membership from year to year
  - For the MA program, the majority of enrollees are administered by the federal government

Risk Adjustment (cont.)

- ACA risk-adjustment mechanism elements that may lead to increased uncertainty in an issuer's financial statements include:
  - Uncertainty as to an issuer's risk score
    - Due to the risk-adjustment mechanism being based on concurrent analysis, as of year-end, the issuer would not possess all the data that will be relevant to calculating its own risk score
  - Uncertainty as to other issuers' risk scores
    - The final payment an issuer makes or receives will be dependent on the relative relationship between its aggregate risk score and those of all issuers participating in a risk-adjustment cell
    - Uncertainty greater in 2014 than subsequent periods

Risk Adjustment (cont.)

- Uncertainty as to issuers' membership exposure
  - ACA could increase uncertainty since it requires issuers to extend the grace period from 30 days to 90 days for a member receiving a premium subsidy via an exchange
- Granularity of the calculation
  - An issuer will have to perform a series of separate calculations for each risk-adjustment cell, which complicates the modeling required to provide effective estimates
- Implications of data reviews
  - Current regulations require a data validation review that could lead to payment adjustments

Reinsurance Benefits

- To alleviate concerns about potential increased incidence of large claims in the individual market with removal of underwriting in 2014, ACA included a transitional reinsurance program
- Program runs from 2014 through 2016 with decreasing benefit levels. Program will extend beyond 2016 if additional funding remains
- Program administered by HHS on a national basis
- Program funded by per capita assessment on commercial health insurance coverage (individual and group markets)

Reinsurance Benefits (cont.)

- Numerous aspects of the reinsurance program may increase uncertainty in the 2014 financial statements
  - Accrual for reinsurance on unpaid claims
    - Regarding excess-of-loss reinsurance, many issuers historically accrued for reinsurance receivables on specifically identified claims only
    - May now consider estimating potential reinsurance recovery on unpaid claims for which no specific information is available

Reinsurance Benefits (cont.)

- Magnitude of reinsurance recovery accrual
  - Since regulations don't require interim settlements, an issuer will be recording an accrual at Dec. 31 for the full year's reinsurance recovery
  - Under either GAAP or statutory accounting, the accrual will complicate any year-over-year comparability of financial statements for an issuer with significant participation in the individual market

Reinsurance Benefits (cont.)

- Potential valuation allowance on reinsurance recoverable
  - There is potential for reinsurance benefits to be reduced due to availability of funds since reinsurance benefits are limited to availability of funds
  - Funding sufficiency may also be a concern in determining the amount of expected reinsurance recoveries to accrue at year-end
  - Potential for denied reinsurance claims
    - The review process for reinsurance claims may lead to some denial of filed claims

Risk Corridors

- 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 program pertains only to qualified health plans both on and off the exchange
- Risk-corridor calculation is to be performed at the plan level but allowable claim costs are to allocated from the state/market level
- Risk-corridor calculation is to be performed after considering any amounts transferred to or from the issuer as a result of the risk-adjustment and reinsurance programs

Risk Corridors (cont.)

- Calculations may require some additional allocations to the state/market level that issuers are not currently performing
- Any accrual calculation is relatively complex needing to integrate with other items
- Calculation is not symmetrical—positive experience in one cell does not necessarily offset negative experience in another cell

New Taxes and Fees

Health Insurance Providers Fee

- Beginning in 2014, any company writing certain types of health insurance on U.S. risks will be subject to the new Health Insurer Provider (HIP) fee
- HIP fee will be assessed on an annual basis, with the first payment due by Sept. 30, 2014
- Most notable adjustment to premiums in HIP fee calculation is that a company not subject to federal income tax only counts one-half of its premiums in the calculation
- Industry practice regarding inclusion of the HIP fee in pricing has been varied

Health Insurance Provider Fee (cont.)

- HIP fee raises a number of issues regarding issuers' financial statements and metrics used by financial analysts:
  - Expense estimation risk
    - Issuers' interim financial statements (especially in 2014), could misestimate the HIP fee amount
    - HIP fee does not raise concerns about inter-year estimation risk, only intra-year estimation risk
  - Earnings emergence implications of revenue/expense mismatch
    - Issuer may not be able to defer the recognition of revenue from 2013 to 2014 (e.g., no UPR can be set up at Dec. 31, 2013)
    - HIP fee could create an upward bias in 2013 and could create a downward bias in 2014
    - Depends on final accounting treatment

Health Insurance Provider Fee (cont.)

- Comparability across issuers subject to different tax code provisions
  - HIP fee is a non-deductible excise tax
  - Differences related to tax status may effect the impact of the HIP fee on the issuer's financial statement
- Customer rebate implications of revenue/expense mismatch
  - Federal taxes and fees are adjustments to the denominator of the ACA's MLR metric
  - If incremental premiums for a year exceed the recognized tax expense, the net effect would be to increase the denominator, decrease the MLR, and potentially increase rebates to customers; if premiums are less than the recognized tax expense, the net effect could be a decrease in rebates

Reinsurance Contribution

- Transitional reinsurance program is funded based on assessments charged to health insurance issuers in the individual and group markets and sponsors of self-funded plans
- Reinsurance contribution will be assessed on an annual basis for calendar years 2014 through 2016 only
- Per the regulations, each contributing entity will submit membership data spanning only the first nine months of the calendar year to federal regulators in November
- Although this program is called “reinsurance,” it may not meet the accounting definition for reinsurance

Reinsurance Contribution (cont).

- 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
- Three key differences between the reinsurance contribution and the HIP fee:
  - More direct relationship between the reinsurance contribution and a particular enrollee than between the HIP fee and that enrollee
  - Greater transparency available with respect to the magnitude of the reinsurance contribution
  - Reinsurance contribution is tax deductible

Reinsurance Contribution (cont).

- Financial reporting implications
  - Expense estimation risk
    - Most common interpretation of final regulation is that each year's national reinsurance contribution is fixed in advance and the total amount of funding generated by that rate may end up differing from the statutory funding target
    - If final regulation is modified to allow an alternative interpretation, issuers will be exposed to estimation risk in their fourth quarter financial statements with respect to amounts recognized in the previous three quarters

Reinsurance Contribution (cont.)

- Expense emergence implications of revenue/expense mismatch
  - The timing issues associated with the reinsurance contribution are similar to those in the example for the HIP fee
- Customer rebate implications of revenue/expense mismatch
  - 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 of the MLR formula

Reinsurance Contribution (cont.)

- Cash Flow Timing
  - Under the regulation, issuers will receive the annual reinsurance contribution invoice from the government in mid-Dec. and will have 30 days to pay the bill
  - The timing gives issuers discretion over whether 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
  - 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 contributions bill in Dec. or in Jan.
- Administration of self-funded business
  - Self-funded plan sponsors are liable for reinsurance contributions

Other New Fees

- Patient Centered Outcomes Research Institute (PCORI) fee
  - Per-member federal tax that applies to plan years ending between Oct. 1, 2012, and Sept. 30, 2019
  - Magnitude of the fee is small—$1 PMPY for the first year and $2 PMPY for the second, with successive increases commensurate with inflation
  - Issuers may include this fee in pricing. Additionally, this fee can be deducted in the MLR calculation as part of taxes and assessments.

Other New Fees (cont.)

- Risk adjustment user fee
  - Per-member fee that will apply to issuers of plans to which the ACA risk-adjustment program applies
  - Intended to fund administrative costs of the risk-adjustment program
  - Magnitude is very small-for 2014, the fee has been set at $0.96 PMPY

Other New Fees (cont.)

- Federally-facilitated exchange (FFE) user fee
  - Applies to issuers of plans offered through a federally-facilitated exchange
  - Similar fees may apply to issuers of plans offered through a state-operated exchange
  - For 2014, the FFE user fee has been set at 3.5 percent of premiums
  - FFE user fee needs to be pooled across an issuer's exchange and off-exchange business, which means that an issuer could be exposed to estimation risk as it prices for the FFE user fee as it makes and assumption regarding the mix of business on and off the exchange

Advanced Payments

Premium Subsidies

- ACA creates premium subsidies in the form of tax credits, paid in advance of tax filing and paid directly to health issuers whose members have income of 100 percent to 400 of the federal poverty level
- 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
- Depending on the timeliness with which the exchange and the government pay the issuer for the advanced payment tax credits applicable to its members, a receivable for these receipts may need to be set up

Cost-Sharing Reduction Payments

- 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
- 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
- Subsidization of cost sharing under the ACA has strong similarities to the Medicare Part D low-income cost-sharing (LICS) subsidy program

Existing Actuarial Liabilities

Claim Liabilities

- Health insurers typically calculate unpaid 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 taking into account trend, seasonality, large claims, inventory, and other operational factors
- There will be considerable uncertainty around the morbidity level of issuers' insured members in 2014

Claim Liabilities (cont.)

- Plan designs also will be changing significantly 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
- Increased provider risk sharing also will have an impact on claims reserves

Claim Liabilities (cont.)

- In periods during which an issuer's risk pool changes significantly, claim liability estimates are based more on pricing assumptions and judgment rather than definitive data on morbidity of new entrants
- Payment patterns also are likely to be impacted by claims operations
  - Need to monitor claim inventory
  - ICD-10 effective date of October 2014 exacerbates operational issues

Contract Reserves

- Some issuers 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
- 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 that the future expected lapse rates differ greatly from original assumptions unless premium deficiency emerges

Contract Reserves (cont.)

- For SAP, the lock-in principle generally is believed to not apply
- Some issuers already may have been making changes to their future lapse assumptions in their 2011 and 2012 reserve calculations, reducing the potential for large impact on reserves when the excess lapses materialize
- 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

Due and Unpaid Premium Asset

- 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 due and unpaid premium asset

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 form other blocks of business
- Some of the issues discussed earlier can affect an issuer's PDR calculations

Premium Deficiency Reserves (cont.)

- One of the main inputs into a PDR calculation involves the timing and magnitude of future rate increases
- 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

Question and Answer

Staff Contact Information

Tim Mahony

Health Policy Analyst (State)

American Academy of Actuaries

1850 M St., NW (Suite 300)

Washington, DC 20036

202-223-8196

mahony@actuary.org

AMERICAN ACADEMY of ACTUARIES